

COMPLIANCE SURVIVAL

COBRA and HIPAA COMPLIANCE SURVIVAL

JULY 2011 Edition

This booklet is in no way intended to provide legal, accounting or professional service for COBRA compliance – simply a basic description of the laws and the compliance responsibilities of the employer. For guidance, the reader is cautioned to refer to the full text of the law, regulations, court cases, announcements and legislative history, all of which are amended and updated frequently.

Ouida Peterson – CONEXIS – 877-266-3947
Cell phone – 214-674-7647 opeterson@conexis.com



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COMPLIANCE SURVIVAL

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COMPLIANCE SURVIVAL

MANAGING YOUR COMPLIANCE RESPONSIBILITIES

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Internal Revenue Code in the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHSA). The basics of the law provide continuation of certain insurance benefits for participants (Qualified Beneficiaries) that may have lost benefits because of specific events (COBRA Qualifying Events). The length of the continuation is determined by the event causing the loss of coverage.

It sounds so simple doesn't it? But, the details of the law are complex – numerous compliance responsibilities with very specific timelines. Tracking activities and actions are a major part of the compliance liabilities. Simple? Yes – if the employer does what the law requires when the law requires it!

While the law addresses continuation of *insurance* benefit rights, it is not a law mandating insurance carriers or third party administrators. COBRA is NOT an insurance law – if it were, insurance carriers and administrators would have the compliance liability and, as with other insurance laws, it would be policed by the Department of Insurance

No - COBRA and HIPAA are *employer* liability laws and the compliance administration and liability are the responsibility of the employer.

COBRA – A SIMPLE LAW

COBRA is a Federal law providing continuation of certain insurance benefits when participants lose insurance eligibility because of specified events. The length of continuation is determined by the loss of coverage reason.

How do participants know about their COBRA rights? The law requires a number of communications – again, with very strict timelines and wording.

The COBRA law is “policed” by the IRS and the DOL – compliance failures could result in financial penalties and fines – not to mention the employer paying claims themselves – the definition of totally self-insured!

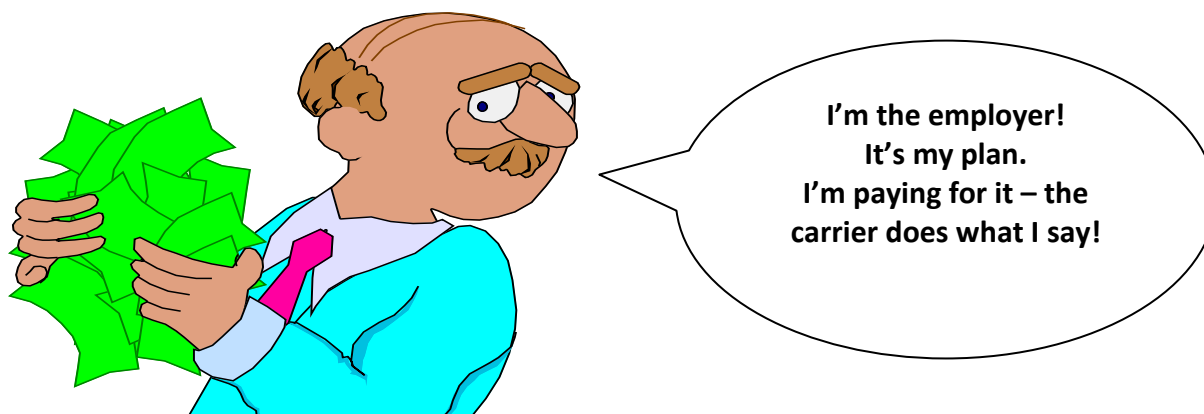
- **Employers** are responsible for compliance liabilities of COBRA
- The **IRS, DOL** are the policing authorities for COBRA and HIPAA Portability
- **Penalties and fines** come in the form of an excise tax assessed by the IRS

Not an Insurance Law -- An *Employer* Liability law

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Again, Federal COBRA continuation is an employer liability law. All required compliance actions are the responsibility of the employer – one small failure can lead to a large fiduciary liability – not only penalties and fines assessed by the IRS but, also the responsibility of paying any outstanding claims themselves.

Of course, if the employer follows the rules of the law, the carrier must support the offering of COBRA continuation – but, if the employer makes an exception or doesn't follow the rules of the law, the carrier has no obligation to provide the coverage.



WHOSE PLAN IS IT?

Too many times employer's say, "it's my plan – I can do what I want!"

NOT EXACTLY! The employer provides the employer sponsored health plan – makes insurance benefits available to their eligible employees and their dependents. As such, the benefit plan must abide by certain Federal and possibly, state laws. The carrier or administrator has an insurance document that details the rules of the plan (the contract). While some rules are determined by the employer and carrier (i.e. eligibility, participation and contribution percentages,) the rules also include the laws specific to that coverage and plan - COBRA, FMLA, coverage and provider benefit mandates. Everyone seems to have a say in this contract language.

The contract or Summary Plan Document is the "bible" of the Plan – there are no grey areas here – that will result in a law suit!

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ABIDING BY THE LAW

If the employer's compliance actions follow the law, the employer must support those activities. But, if an employer makes an exception or steps outside of the law, the carrier will not support that.

EXAMPLE - I used to work for you – left the company four months ago. I see you in the grocery store one day. We are having a friendly conversation but, suddenly I say “by the way – you didn't offer me COBRA when I left!”

Now why did I suddenly bring up COBRA - four months after I left the company? You know why – I have a claim – and how big is that claim? Bigger than four months of back COBRA premium! If it wasn't, I would just pay the claim and go on down the road.

But, when I say you didn't offer me COBRA – what do you do? You immediately reach in your bag and pull out your COBRA paperwork. You DO carry your COBRA paperwork with you everywhere you go don't you? You will after you read this Compliance Manual!

The ex-employee signs up for COBRA right there in the grocery store. The employer grabs the application and COBRA premium and run to their carrier. “Oh, the funniest thing just happened – we had an employee that was covered on our health plan – they quit four months ago and we just totally forgot to offer them COBRA. But, here is everything now – their application and back premium – let's get them reinstated four months back!”

Can you hear the laughter! The carrier knows they have a claim and they know it is a big one!

Hard to understand why the employer thinks their *carrier* ought to pay for the *employer mistake!* The employer knows who works for them and who doesn't – the carrier doesn't know until the employer tells them. That is why COBRA is an employer law not a carrier law.

This little slip could result in a COBRA penalty of \$110 per employee, per dependent, per day for every day COBRA is not administered correctly. AND, the employer would have the responsibility of paying all claims – not only past claims but, also any claim incurred during the COBRA eligible time – 18 or 36 months.

Again, a simple law if the employer does what is required by the law in the timelines of the law. If the employer does that, they are protected by the law and their carrier must support the COBRA offering.

But a compliance failure could result in an Excise Tax, ERISA Penalty, claim payment, damages, Attorney Fees – it is a huge financial liability!

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EMPLOYER LIABILITY

If an employer elects to contract with an outside administrator for their compliance responsibilities, it is important to confirm what that compliance activities that administrator will perform – what will they do – what is left for the employer to do? This should be clearly explained in the service agreement – but, look closely – that is also where the loopholes are hidden.

Shift not only the work but, most importantly, the liability. Look for *indemnification* wording in the contract. And it should be a very strong indemnification clause – indemnification for all penalties, fines and claims. Without indemnification, all compliance liability remains with the employer. The only thing the employer is paying for is a glorified letter-writing service.

RISK ANALYSIS

Proper compliance activities involve much more than just sending a letter. Compliance procedure reviews should include a time and risk analysis – you may discover outsourcing the activities and liability to be the most cost effective solution.

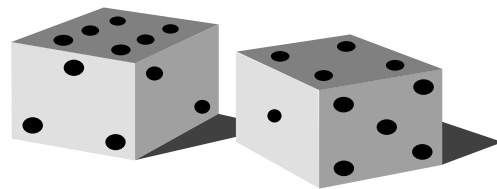
A constant vigilance of legislation and litigation is required to properly maintain an accurate perspective of an employer’s compliance liabilities. While a good compliance program includes tracking legislative updates, it also includes monitoring, auditing and tracking compliance activities. A good program providing a consistent administrative “picture” is the best compliance protection.

COMPLIANCE RESPONSIBILITIES – self-administration or outsourced?

It’s Not Just a Letter!

- Track legislative changes
- Track Litigation

- Monitor Your Compliance Program
 - Notices
 - Elections
 - Premium payments
 - Eligibility



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HOW TO USE THIS MATERIAL

The COBRA legislation, enacted in July 1986, allows employees and/or their dependents the opportunity to temporarily continue their health plan benefits if coverage eligibility is lost due to specific Qualifying Events. The continuation time period is determined by the loss of coverage reason or qualifying event.

Since its effective date, the COBRA law has been changed through amendments, guidelines, IRS and DOL memorandums, other laws, litigation and even Supreme Court Rulings.

The February 3, 1999 Final COBRA Regulations incorporated many of the changes since the enactment of the original law. We received NEWER Final COBRA Regulations January 10, 2001. Even NEWER Final Regulations were provided May 26, 2004. Reviewing all three of these Final Regulations gives you a full picture of the law and its requirements. There isn't just ONE COBRA law.

Other laws have also impacted COBRA obligations – HIPAA Portability Act of 1996, The Trade Act of 2002 and then, in 2009, The American Recovery and Reinvestment Act (ARRA) gave eligible participants a 65% subsidy of their continuation premiums from the Federal Government. Eligibility for this subsidy was limited to covered participants losing their Health Plan benefits as a result of an involuntary termination of employment between September 1, 2008 and May 31 2010. While the eligibility for the subsidy was a short timeline, this law added to the compliance communication, eligibility tracking and premium flow responsibility.

This handbook is a good basic guide to understanding the COBRA laws but, is in no means meant as a single source compliance solution. It is simply a basic explanation of the law in a language we can all understand.

Understanding the law and putting it in action is the employer responsibility. Constant awareness and review of your COBRA activities is a must for keeping any program in compliance.

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Now that we have begun down the COBRA Compliance road, let's see what is required to keep your Plan on track. Before we can see where we need to go, we better see where we are – we will first start with a COBRA Self-Audit.

COBRA and HIPAA Self-Audit

An IRS audit letter requests the following information to be provided –

- Written COBRA procedures (manual with company instructions of COBRA actions)
- Documentation of program design and program updates
- Documentation of program monitoring
- Proof of COBRA Training

Required Notifications Include:

- General Notification (to all new insurance enrollees)
- Qualifying Event Election Notification (include expiration notice)
- Not Eligible for COBRA Notice
- COBRA Ending Early Notice
- Stacked Event Notification
- Disability Extension Notification
- Conversion Notification
- Premium Billing Notifications

Optional Notices

- Forms to document status changes
- Open Enrollment Notice
- Documentation of updates within notices
 - mailing procedures to meet current requirements.

Employers are responsible for tracking

- Each notice (recipient, date & content)
- COBRA periods
- Documentation of notification language updates (1986-present)
- Documentation of procedural updates (1986-present)
- Documentation showing consistency in procedures

If audited, the IRS or DOL will review all compliance actions. Consistency in compliance activities is critical – the proper action at the proper time every time. That is what an auditor wants to see.

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PROCEDURE MANUAL

One of the first things the IRS or DOL audit requests is a copy of a company's written COBRA and HIPAA Procedure Manual. And yet, many employers don't have their procedures written.

- *"We have all the information in the files"*
- *"It is all in Mary's head – it's not written"*
- *"We outsource our COBRA – we don't need a manual – they do it all!"*

None of these are sufficient answers to an auditor. A written COBRA Procedure manual is required of every employer. Even if the employer has outsourced the activities to an administrator, carrier or third party, maintaining a procedure manual is still required.

The manual is a guide of when and what must be done to be in compliance. It should have the basics of the law and the procedures an employer follows when an event occurs or action is required. Even if the employer has outsourced their COBRA responsibilities, they must still maintain a working knowledge of the law in order to know when to tell their outsource solution COBRA action is necessary.

Many times an auditor will ask the employer for their last three years of payroll records. From those three years, they will pick 10 names and want to see proof of the compliance communications provided to these people.

If any of those 10 people were ever covered on the employer sponsored health Plan, there should be proof of providing a COBRA General Information notice.

If any of the 10 lost coverage due to a COBRA Qualifying Event, there should be proof of providing a COBRA election notice.

The auditor will then want to see documentation of all COBRA participants – elections, payments, end of coverage notices. All of this must be provided and tracked by the timelines of the law.

If an employer is lacking in a compliance activity, the IRS could penalize the employer \$110 per employee, per dependent, per day for every day COBRA was not done properly. The employer must show proof of consistent compliance activities.

COMPLIANCE SURVIVAL

WHAT SHOULD BE INCLUDED IN A COBRA PROCEDURE MANUAL?

COBRA Procedure Manual

- **Basics of the Laws**
- **Update Sources (Legislation, Litigation, IRS and DOL rulings, Compliance consultants)**
- **Copies of Notices**
- **COBRA Premium calculations**
- **Corporate Compliance Philosophy (i.e. how does the company handle a less than significantly short payment)**
- **Exception Practices (who can make exceptions)**
- **Proof of Training**
- **Tracking System – established, monitored and updated**
- **Audit Record**
- **Activity Standards (i.e. what to do if a lawyer calls . . .)**

➤ *Basics of the Laws*

The COBRA & HIPAA Procedure Manual should include the basics of the law – a paper copy is not required. It is best to download the laws to your computer. This way you can use the “word search” capabilities to find the area of the law you may be seeking. Electronic copies of the law may be found on the IRS and DOL websites www.irs.gov or www.dol.gov/ebsa - the Department of labor website provides a number of additional compliance resources. Look for “compliance assistance” – this link provides model compliance notices and basic information for a number of employer liability laws – COBRA, HIPAA, FMLA, Women’s Cancer Rights . . .

Another source for downloading the law is on the CONEXIS website www.conexis.org - From the Home Page, click on the word RESOURCES. Here you will find downloadable copies of a number of employer compliance laws – COBRA, HIPAA Cafeteria Plan laws.

But remember, for COBRA you must download the 1999, 2001 and 2004 Final Regulations – each regulation refers back to the previous. You must have all three for a full COBRA “picture.”

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COBRA Procedure Manual (continued)

➤ ***Update Sources (Legislation, Litigation, IRS and DOL rulings)***

Your manual must include Update Sources – how do you keep up with the changes in the compliance laws? Obviously, you probably do not read the Federal Register every day. But, what sources do you have to track the changes in the laws? While you could periodically monitor the IRS and DOL websites, it would be difficult to find the changes.

You may want to subscribe to Insurance Professional or Employee Benefit Specialist websites and newsletters. Legislative and Litigation Review Services or a Benefit Publication may also provide an update resource. Obviously, an excellent source for updates is your Compliance Administrator.

➤ ***Copies of Notices***

Sample copies of all Communications of Compliance should be maintained in your manual.

- HIPAA Special Enrollment Rights Notice
- General COBRA Notice
- HIPAA Privacy Notice
- HIPAA Certificate of Creditable Coverage
- COBRA Eligibility Notification
- COBRA Unavailability Notice
- Early Termination Notice

Remember, the auditor may want to see your notices. Be sure your notices are kept up to date. Sending a notice without all of the required information is seen as not providing a COBRA notice at all.

➤ ***COBRA Premium calculations***

A COBRA premium page must be maintained in your manual. This page should provide an actuarial calculation of the premium charged your COBRA participants (see page 55) for allowable COBRA premium calculation procedures).

➤ ***Corporate Compliance Philosophy***

Less than significantly short payment The COBRA law provides two options for handling less than significantly short COBRA payments – which option will you take? You must know now, before a short payment is received (see page 55) for short payment and NFS procedures).

COMPLIANCE SURVIVAL

COBRA PROCEDURE MANUAL (continued)

➤ **Exceptions**

Your manual should identify the Corporate Officer with COBRA and HIPAA exception authority. This must be someone at the company that has the authority to sign or over-ride a contract. Of course, it is best that exceptions not be made. Exceptions open your company to discrimination liabilities and unnecessary financial risk and exposure. Remember, if you follow the letter of the law, the law will protect you. But making an exception is stepping outside the letter of the law – and also outside the protection of the law.

➤ **Proof of Training**

The IRS monitors the training schedule of the personnel responsible for your company's COBRA and HIPAA activities. Update training should be received at least once a year – while the law may not change every year, frequent litigation gives us clarification of the laws. Training can also show inconsistencies in procedure and gives an opportunity to clarify corporate compliance guidelines.

➤ **Tracking System – established, monitored and updated**

How does your company discover a COBRA or HIPAA compliance event has occurred? What is the timeline of information flowing from payroll to the HR or Employee Benefit Department? If there are satellite offices, what is the corporate procedure and timeline for the satellite office to communicate to corporate? Who is the point person for receiving COBRA event notification?

➤ **Audit Record**

The IRS expects companies to audit their compliance activities and program at least once a year. Don't wait for the "knock on the door" – The IRS and DOL expect employers to do self-audits and may want to see the result of those audits.

➤ **Activity Standards (i.e. what to do if a lawyer calls . . .)**

EVERY employee of your company should know what to do if a lawyer, government official, or the press calls on their line. This isn't just for COBRA activities. A company should have a strong corporate policy of who can respond to such inquiries. Nothing short of "failing to transfer the call is ground for immediate termination of employment." YES, it IS that important. What do you want to read about your company on the front page of the paper?

COMPLIANCE SURVIVAL

COBRA COMPLIANCE REQUIREMENTS

A SIMPLE LAW

The COBRA law is actually a very simple law. It identifies *Qualified Beneficiaries* - employees and dependents active on the coverage the day before the COBRA qualifying event. Should a Qualified Beneficiary lose insurance benefits because of certain specified reasons (*qualifying events*) they are allowed to continue the same Health Plan benefits as the non-COBRA participants. These benefits will be provided on a self-pay basis. This premium may also include a 2% administrative fee.

While the concept of the law is simple, the administration is much more difficult. Strict timelines for notices, elections, and payments are specified in the law. Stepping outside, or not following the provisions of the law, could result in the employer totally self-insuring a claim or risking discrimination or litigation.

Again, this is an employer law. If the employer stays within the letter of the law, the carrier or third party administrator must abide by the law. But, if the employer steps outside the letter of the law (exceptions), they will likely be stepping outside by themselves – the carrier is not required to support the “outside of the law” activity.

COMPLIANCE SURVIVAL

WHO MUST COMPLY

COBRA is a Federal law and applies to ERISA defined “group health plans” – an employer sponsored health plan providing medical care to participants either directly or through insurance or reimbursement. This explains why the employee count “test” is determined on a Jan 1 to Dec 31 timeframe – not the insurance plan year or renewal year.

All health plan-sponsoring employers having 20 or more employees over half the typical business days in the previous calendar year, must comply with COBRA continuation provisions for participants losing insurance during the next calendar year. Notice those underlined words – this simple guideline needs additional explanation.

- 20 or more employees – not employees covered or eligible for insurance – remember, COBRA isn’t an insurance law – it is an employer law – how many employees does the employer have – we will go into detail a bit later on how to count the employees – but, for now let’s just say count W2s.
- over half the typical business days – this will be different for each employer – some companies “typically work 5 days a week – some 6 or 7 – the calculation is made by each employer’s action. And when we say of half the typical work days, it is not contiguous days. A company could have the following –

○ January – 22 employees	
○ February – 20 employees	
	● March – 19 employees
	● April – 19 employees
	● May – 18 employees
○ June - 20 employees	
○ July – 21 employees	
○ August - 22 employees	
○ September – 21 employees	
	● October – 19 employees
○ November - 20 employees	
	● December - 19 employees

Never for 6 straight months did the employer have 20 or more employees – but, when calculated on half the typical workdays in the year, there are 20 or more – this is a COBRA mandated employer.

- Previous Calendar Year - the number of employees last year dictates the continuation liabilities for this year. At the end of this year, the employer will count employees to determine the continuation mandate for next year’s events – those occurring January 1 and after.

COMPLIANCE SURVIVAL

WHO MUST COMPLY (continued)

EXEMPTED EMPLOYERS

The only employer exceptions are:

- The Federal Government
- Church Plans (as defined in section 414 (e) of the IRS Code)

Public entities appear to be exempt from the COBRA law, however the Public Health Law requires them to abide.

The only truly exempt employer is the church – the church or Association of Churches – not simply being *associated* with the church an Association of Churches. The Baptist Church, the Southern Baptist Convention; the Presbyterian Church, the Presbytery; those are Affiliations of the church. Simply being affiliated with the church does not make the entity a church – nor does it make that entity exempt from Federal COBRA mandates.

EXAMPLE: The hospital associated with the church is a hospital – not a church – they must abide by the COBRA law. Same for church sponsored universities.

There always seems to be a question with the school or daycare facility sponsored by the church – is that a church or school or daycare? Doubtful that school or daycare could meet the IRS code definition of a church. These questionable situations need the advice of a lawyer – one that will be standing by them in court if there is a problem.

THE COBRA EMPLOYEE COUNT

The employee count process changed with the 2001 Final Guidelines but, still maintains this premise –

- this is a basic employee count - eligibility for insurance is not a determining factor

The 2001 Final Guideline employee definition included all full-time and part-time employees, officers and owners. Now the officer and owner words have been removed in the law but, if the officers and/or owners are employees, they are in the count.

In the 1987 proposed guideline, this was a simple “body count” however; the 2001 guidelines use a full-time equivalency formula when counting part-time employees.

COMPLIANCE SURVIVAL

THE COBRA EMPLOYEE COUNT (continued)

Part-time employees are normally not eligible for insurance – the isn't saying they must be offered insurance or that they will ever be eligible for the insurance – the law simply says they are in the employee count.

<p style="text-align: center;">ALWAYS COUNT</p> <ul style="list-style-type: none">• Full-time and Part-time • Part-time – by full-time equivalency formula $\begin{array}{c} \# \text{ hours worked as PT} \\ \div \\ \# \text{ hours required to be FT} \\ = \\ \text{Part-time full-time equivalent ratio} \end{array}$

EXAMPLE: A company has 4 part-time employees that work 20 hours a week. The employer says, the company requires that you 40 hours a week to be considered full-time.

$\begin{array}{c} 20 \text{ hours a week actually worked} \\ \div \\ 40 \text{ hours required to be full-time} \\ = \\ 50\% \end{array}$
--

Each of the part-time employees is equivalent to 50% of a full-time employee. These 4 part-time employees will count as 2 full-time employees.

BUT WAIT – if you think someone must work 40 hours to be considered a full-time employee – read that insurance contract language for an eligible employee in the health plan – doesn't it say a full-time employee working a minimum of 30 hours a week? If the employer requires something different, the language in their insurance documents must be changed.

The COBRA law doesn't dictate the number of hours for full-time – that is left to the employer but, they need to be certain there are no discrepancies in what the insurance contract says and what the employer does!

And, regardless of the "label" attached to them - seasonal, temporary, hired on probation . . . If they are not full-time, they are counted by the part-time/full-time equivalent formula.

COMPLIANCE SURVIVAL

WHO IS NOT AN EMPLOYEE?

1099 Independent Contractors are NOT employees – they are independent contractors – they are not in the employee count. But employers should be very careful what they require of an independent contractor. Review IRS Form SS-8 – Determination of Worker Status. This form looks at activities, behavioral control, financial control, relationship of worker and the firm, services provided by the worker. The IRS is very specific that these people truly be “independent” workers – if an employer controls too much of what they do, when and where they do it, they could find that these people are actually employees by the IRS guideline – possibly considered part-time employees – but, they may be employees.

The IRS has become diligent in policing these situations. Many employers are terminating full-time employees – hiring them back as independent contractors – but, they are doing the same thing as before. THE IRS has a big problem with this.

LEASED EMPLOYEES – some employers have contracted with Professional Employer Organizations (PEOs) to fill their employee needs. These Employee Leasing Companies hire employees – the leasing company is the “employer of record” – but, the PEO leases employees to different companies.

The workers go to a company (the worksite employer) to work but, they are paid by the PEO. It may look like they are working for ABC Company but, their employer is actually the PEO. As such, they are not included in the “employee count” for the worksite employer. They are in the employee count of the PEO.

RETIREEES or FORMER EMPLOYEES – just as the name implies, these are not employees – they may be covered on the insurance plan but, they are not in the employee count to determine the continuation responsibility of the employer.

COMPLIANCE SURVIVAL

COMMON OWNERSHIP – CONTROL GROUP - HOW MANY EMPLOYERS

The COBRA law relies on other laws such as ERISA, IRS and DOL to define employers. The law includes special COBRA compliance provisions in instances of common ownership, multiemployer plans and multiple employer plans. It is critical that an employer understand their specific identity when determining their compliance liabilities.

COMMON OWNERSHIP PROGRAMS

If companies are commonly owned by an individual or individuals, it is likely that the companies should be viewed as one when determining a COBRA compliance obligation. For COBRA purposes, the term *employer* is defined by using the controlled group rules of the IRS Code Section 414 (b), (c), (m) and (o). these definitions prevent a single employer from structuring their companies to look like multiple companies in order to avoid the application of various tax rules.

An example of this would be when determining the employee count. The code identifies a controlled group relationship if

- one entity owns at least 80 percent of the stock of another entity (parent-subsidary relationship)
- A “brother-sister” control group of corporations exists if five or fewer persons own at least 80 percent of the total stock value or voting power of each corporation and own more than 50 percent of the stock value or voting power of each corporation.

When determining the “employee count” to determine the continuation obligation, the COBRA law requires all “commonly owned employees” to be counted.

**TWO different companies - TWO different tax ID numbers
TWO different health plans
15 employees each
ONE OWNER**

Even though they appear as two companies, the common ownership brings them together when making a COBRA determination. The result is ONE employer with 30 employees and both employer plans are COBRA plans

Most important question – Is there anything else you own that we should know about? Even if the employer doesn’t provide insurance benefits to the employees of one of the companies, those employees are still in the employees count.

COMPLIANCE SURVIVAL

HOW MANY EMPLOYERS (continued)

MULTI-EMPLOYER PROGRAMS

A Multi-Employer Plan is a plan to which more than one employer is required to contribute (i.e. collective bargaining agreement plans). In most instances, it is the employer that has the COBRA compliance responsibilities – however, in multi-employer plans, it is the PLAN that must comply. While each employer is looked at individually, if ONE employer exceeds the “20 or more” employee count test, the entire plan (ALL employers) become COBRA mandated Plans.

MULTIPLE-EMPLOYER PROGRAMS

Often times, multiple employers come together to gain the pricing and negotiating advantage of “numbers” (i.e. Associations or Multiple-Employer Welfare Arrangements - MEWAs). These multiple-employer plans are viewed differently from a multi-employer plan when the COBRA test is given. Each employer plan is looked at individually when making the continuation determination. Each employer in the Plan stands on their own employee count when determining the continuation obligation.

CONTINUATION OBLIGATION CHANGES

Employers are adding employees and losing employees all the time. The employee count for the previous year dictates the continuation obligation for the following year – that obligation could change from year to year.

In 2010 an employer had 22 employees over half the typical work days in the year. Beginning January 1, 2011, the employer has a Federal COBRA continuation obligation to any participate have a COBRA qualifying event 1-1-11 and after.

One person quits in March – they are offered and elect 18 months of COBRA continuation
Two more people quit in May – they are offered and elect 18 months of COBRA continuation

Business is on a slight decline so the employer does not replace these employees and continues with 17 employees for the remainder of 2011. The employee count for 2011 is less than 20. The employer no is no longer Federal COBRA mandated as of January 1, 2012.

BUT, what happens to the people the employer already had on COBRA? They still have their full COBRA continuation opportunity. They lost coverage under the Plan when it was COBRA mandated. Nothing changes for them just because their employer’s continuation obligation changes. Or even the other way – as long as there is still an employer sponsored health plan in place for ANY active employee, no one’s continuation opportunity changes because their previous employer gained or lost employees.

COMPLIANCE SURVIVAL

WHO MUST BE OFFERED COBRA – QUALIFIED BENEFICIARY

The COBRA law gives us a whole new vocabulary with words like qualified beneficiary and qualifying events. A qualified beneficiary is an individual covered under the employer's health plan the day before the COBRA qualifying event. The law defines a qualified beneficiary as

- a covered employee
- a covered legal spouse of the employee
- a covered dependent child of the employee
- any child born to, or placed for adoption with, the covered employee during the period of continuation coverage (added by the HIPAA Portability law of 1996)

Each Qualified Beneficiary has their own individual right to continuation. Nothing is contingent upon the employee continuing.

Qualified Beneficiaries have a number of other special benefits through the COBRA law. These benefits will be discussed later when we talk about extending COBRA coverage more than 18 months (second qualifying events; Social Security Extension . . .).

The COBRA law also provides benefits for NON-Qualified Beneficiaries. These are dependents (other than newborns or adopted children) added to COBRA coverage after it has begun. Domestic Partners and spouses of the same sex may also fall into this category.

The COBRA law is a Federal law and is mandated by the 1996 Defense of Marriage Act and the 2004 Working Families Tax Relief Act. The employer determines who is eligible for insurance benefits as an active employee and their dependents but, Federal Law dictates who is eligible for COBRA continuation.

Continued eligibility for non-qualified beneficiaries IS contingent upon the original COBRA beneficiary remaining eligible and continuing coverage. A non-qualified beneficiary does not have their own right to COBRA continuation.

Much confusion surrounds same sex partners and COBRA. Too many employers say "the law says they aren't qualified beneficiaries – they can't have COBRA." This is not totally correct. Agreed - they are not qualified beneficiaries as defined in the law – not a legal spouse under Federal definitions. They are not eligible for COBRA as a qualified beneficiary – but, they are eligible for Federal COBRA as a non-qualified beneficiary. Not eligible in their own right but, able to continue if the original employee continues.

COMPLIANCE SURVIVAL

WHAT PLANS MUST BE OFFERED

For COBRA purposes, a group health plan is

“a plan maintained by an employer or employee organization to provide health care to individuals who have employment–related connection to the employer or employee organization or to their families.”

Many people mistakenly interpret the “health plan” wording of the law to mean that only health insurance plans must be offered under COBRA. This is incorrect. The law goes on to clarify that “a health plan” includes plans that reimburse medical expenses through

- health
- dental
- vision
- prescription drug programs
- Health Flexible Spending Accounts
- Employee Assistance Programs
- Health Reimbursement Arrangements.

The 1999 Final COBRA Regulations also explained that an employer contribution is NOT a COBRA plan requirement –

“a group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual’s employment-related connection to the employer or employee organization”

Employers must review all plans providing COBRA eligible benefits to determine any possible COBRA obligation.

If a participant is covered on COBRA eligible coverage and has a COBRA qualifying event that causes them to lose that coverage the same way it was provided to them before the event, they have a COBRA opportunity. Did they lose anything? Not just the benefit but, even the employer contribution – that is a COBRA opportunity.

If they can continue the same coverage at the same price and same benefit level – there is no COBRA obligation but, if anything is lost . . .

COMPLIANCE SURVIVAL

SOME VOLUNTARY PAYROLL DEDUCT PLANS

A Voluntary Payroll Deduct Plan is a plan where the employer makes the coverage available but, makes no contribution to the coverage – it is 100% paid by the employee. The employer acts as the premium collection service. They payroll deduct the premium and forward it to the carrier.

When the 1999 Final COBRA Regulations “clarified” the provision of “regardless who pays the premium” it brought SOME Voluntary payroll Deduct plans into the COBRA world. It all depends on the type of plan.

Voluntary Payroll Deduct plans come in two different types – individual plans and group plans.

Portable Individual Payroll Deduct Plan

Some payroll deduct plans are truly portable individual plans. The coverage is an individual policy owed by the individual. When an employee leaves, they take the policy with them and simply change the billing address to their home.

If voluntary payroll deduct plan is of this type, it is truly portable. They take the coverage with them when they leave – they continue the coverage at the same price and same benefit level. They didn’t lose anything - there is no COBRA obligation for the employer.

COBRA Required Payroll Deduct Plan

However, some payroll deduct plans are actually group plans and eligibility is based on employment or employee organization membership. With these plans, loss of eligibility results in loss of coverage. That is a COBRA obligation for the employer.

Your question should be –

“Can they take it with them at the same price and the same benefit level?”

If the answer is “YES” they haven’t lost anything – there is no COBRA obligation.

BUT, if the answer is “NO” they have had a loss due to a COBRA qualifying event - the employer must off them the opportunity of COBRA continuation. Now they can continue that same coverage and pay the same rate PLUS the COBRA 2% administrative fee.

COMPLIANCE SURVIVAL

WHAT PLANS MUST BE OFFERED (continued)

One Plan – Separate Plans

Employers should also examine the number of “plans” offered. While a controversial area, it is a critical step of compliance to determine “one” plan or “multiple” plans. For example, if an employer offers a package health plan and dental plan, must a COBRA participant elect both health and dental, or can they continue either plan?

From the 2001 Final Regulations we find that a plan will *constitute one health plan, unless –*

- 1) It is clear from the instruments governing an arrangement to provide health care benefits under separate plans;*
- 2) The arrangement or arrangements are operated pursuant to such instruments as separate plans”*

Many employers have determined that programs administered through separate contracts or policies, are separate “governing instruments” and COBRA participants can pick and choose between plans. However, benefits provided through one “governing instrument” (dental benefits as a rider to a health contract – integrated plan) require the plan be continued as one.

The original COBRA law of 1996 and the 1987 Proposed Regulations listed “core and non-core” benefits. Core benefits were health and non-core was dental and vision. A participant must be allowed to continue at a minimum, core benefits only. Obviously, this was a problem for those integrated plans where everything was under one contract and one rate – difficult to separate the benefits.

Understanding the problem (12 years later) the “core and non-core” language was removed from the final regulations and preplaced with “instrument governing the arrangement” – every instrument is a separate COBRA opportunity.

With this provision, an integrated plan – a health contract with dental and vision benefits included is ONE contract – ONE instrument governing the arrangement. This COBRA opportunity is all or nothing.

BUT, if the benefits are provided through separate contracts, even if from the same carrier, if it is written as separate contracts, it is a separate COBRA opportunity – for each qualified beneficiary. The employee may only want to continue the dental benefits but, the qualified beneficiary dependents may want health, dental and vision. Separate contracts – a separate opportunity for each.

COMPLIANCE SURVIVAL

WHAT PLANS MUST BE OFFERED (continued)

COBRA and Health FSAs

Health Flexible Spending Accounts, as defined by the IRS, are self-funded health plans and COBRA eligible. If FSA plan can qualify for an exception, COBRA continuation is not required to be offered. This provision is confusing and the best advice may be – contact your Health FSA administrator for guidance in determining a COBRA obligation.

Qualifying for the Exception

To qualify for the exception, the health FSA must meet the following two conditions:

- 1 – The Health FSA must be exempt from HIPAA; (HIPAA Exemption) a two prong test
 - a) The maximum benefit under the health FSA cannot exceed two times the employee’s salary reduction for the year or, if greater, the amount of the employee’s salary reduction plus \$500 – maximum benefit condition.
 - b) The employee must have other coverage available under the group health plan of the employer and the other coverage cannot be limited to benefits which are excepted benefit under HIPAA – availability condition

- 2 – The maximum annual COBRA premium chargeable for health FSA continuation coverage must equal or exceed the maximum annual health FSA coverage amount (Premium Exemption).

If your plan cannot qualify for the exemptions, the Unreimbursed Medical Expense Account portions of your Flexible Spending Account may result in a COBRA obligation.

To make the COBRA determination, the status of the Unreimbursed Medical Expense Account must be reviewed.

“Why would anyone want to COBRA their Health FSA – they can’t pay for it with pre-tax dollars – they don’t work here anymore!”

YES, but, they can pay for their Health FSA COBRA premium with post-tax money and then they are still participants in the FSA Plan – they still have access to their money. They must be an active participant in the Plan when they incur the unreimbursed medical expense. The only they way can be an active participant is as an active employee or electing COBRA continuation on the Health FSA.

COMPLIANCE SURVIVAL

WHAT PLANS MUST BE OFFERED (continued)

The 2001 Final COBRA Regulations provide a formula for determining the employer's COBRA obligation. If the account has been overspent, no COBRA offering must be made.

FSA FORMULA

If the remaining benefit available is less than the amount left to pay until the end of the benefit plan year, then no COBRA offering should be made. They have overspent their account

However, if the benefit available is MORE than the amount left to pay, there is a COBRA obligation.

Because of the "use it or lose it" provision of the FSA, COBRA continuation is offered only until the end of the current FSA plan year.

HEALTH FSA COBRA FORMULA

Based on the status of their account when they lose eligibility because a COBRA event



**Benefit Left Available
Vs.
Amount left to pay to the
END of the current Benefit Plan Year**

- **If Benefit is MORE than they have left to contribute, COBRA is offered**
- **If Benefit is LESS than they have left to contribute, no COBRA is offered**

COMPLIANCE SURVIVAL

WHAT PLANS MUST BE OFFERED (continued)

REGION SPECIFIC COVERAGE

Qualified Beneficiaries need only be offered the coverage in effect prior to their qualifying event. However, COBRA coverage is not just claim benefits, it is also the other parts of the benefit program. Qualified beneficiaries are eligible for benefits, open enrollment opportunities, adding dependents . . . A good rule to remember is

“Anything an active participant can do, a COBRA participant can do, plus a little more”.

The regulations make special mention of qualified beneficiaries and region specific benefit programs – a plan requiring eligible participant to live in a specific service area – their home address must be in a specific zip code area.

What if a qualified beneficiary moves from the region - specific service area? Can they change plans? They have the same rights as a non-COBRA participant.

If a qualified beneficiary participates in a region-specific benefit package that will not service his or her needs in the area to which he or she is relocating, the qualified beneficiary must be given an opportunity to elect alternative coverage that the employer or employee organization makes available to active employees. Ask the question – if an ACTIVE employee moved from the specific service area, what would they be allowed to do? Change to another plan? Then that same opportunity must be made available to the COBRA participants.

If the employer only offers a region specific plan, and has no employees in the area where the COBRA participant has relocated there may no longer be a COBRA obligation.

ALTERNATE COVERAGE

Insurance benefits are not required to be totally lost for a COBRA Qualifying Event to occur - simply a difference in the way benefits were provided. For instance, a number of employers allow retirees to remain on the insurance plan until they reach Medicare Entitlement. Some would say, this retirement is NOT a COBRA qualifying event – coverage was not lost. However, the 1999 Final Regulations discuss instances where an employer may have a COBRA obligation. Remember, a COBRA opportunity must be made if they lose coverage the say way they had it as an active employee. Not only the benefit level but, loss of employer contribution can cause a COBRA qualifying event.

Even if they are still eligible for benefits on the plan, there may still be a COBRA obligation. Alternate coverage provisions normally come into play with Retiree Plans.

COMPLIANCE SURVIVAL

WHAT PLANS MUST BE OFFERED (continued)

Alternate Coverage (continued)

The employer allows Retirees to remain on the group health plan but, HOW?

Is the contribution level for the Retirees the same as the employer makes to the non-COBRA or active participants? If the retiree is required to pay a larger portion of the premium, then there has been a COBRA Qualifying Event. They have lost benefits the same way they had them as an active employee. They must be offered COBRA – AND, the alternate to COBRA.

COBRA vs. Alternate to COBRA - The retiree has a decision:

- **COBRA – same benefits as provided to the non-COBRA participants but, pay 102% premium for 18 months or as long as eligible, OR**
- **Alternate to COBRA Retiree coverage – same benefits available to the active employees and the employer pays a portion of the premium BUT, this arrangement is available only for as long as there is a retiree plan**

Don't let the employer think "they can keep the coverage – I don't have to offer COBRA."

If they have lost anything – benefits or employer contribution, there has been a COBRA qualifying event. They MUST be offered COBRA.

The Alternate to COBRA Plan must be as good as what COBRA would have been for as long as COBRA would have been.

What if Retiree was given the choice of COBRA or the Retiree Plan but, in 4 months the employer decides to do away with the Retiree Plan – what will happen to those Retirees.

Should the retiree plan be cancelled, the employer must review each participant in the retiree program. Any participant on the retiree plan for less than 18 months (the time they would have had COBRA), the coverage must be continued for the remainder of the 18 – month period.

If the employer never properly gave them the "choice" of COBRA or the Alternate, they must offer the full 18 months of COBRA continuation.

COMPLIANCE SURVIVAL

COBRA QUALIFYING EVENTS

The COBRA law specifies that COBRA continuation be offered only if coverage is lost as the result of specific Qualifying Events. The law defines loss of coverage as

“ceasing to be covered under the same terms and conditions as in effect immediately before the Qualifying Event”

The event determines the length of continuation available.

18 - MONTH EVENTS

18 - Month Events provide a continuation opportunity for the employee and dependents.

- Termination – Voluntary or Involuntary (Exception – Gross Misconduct)
- Reduction in hours
- Layoff

Terminations due to Gross Misconduct seem to be the most contentious. There is no clear definition of gross misconduct – not in the COBRA law or any other Federal labor law. Many an employer has found that what they thought should be gross misconduct isn't. Unfortunately, this discovery is made in court. Many States have a gross misconduct definition in their own State Labor Code.

Best Advice – contact a lawyer to be sure you have a good gross misconduct firing – the least of your problems will be COBRA if your firing isn't a good one!

AN EVENT IS AN EVENT WHEN?

There is a COBRA obligation only when one of the specified events causes someone to lose their eligibility for coverage. The event is the LOSS of coverage – not just the event.

Look at reduction in work hours – the insurance contract specifies that eligibility is a full-time employee working 30 hours a week.

A covered employee was working 40 hours a week but, their hours are cut to 32 hours a week. Yes, they had a reduction in hours but, not reduced so much that they lost eligibility for the insurance plan. That reduction in work hours did not cause them to lose their benefits – no COBRA event has occurred.

COMPLIANCE SURVIVAL

COBRA QUALIFYING EVENTS (continued)

The qualifying event occurs upon the loss of coverage because of the event. An employee quits on July 8 but, the insurance contract specifies that coverage will continue until the last day of the month – the actual COBRA qualifying event is July 31 – when they lose coverage because of the event.

Severance Packages Including Insurance Benefits

Many employers include insurance benefits in severance packages –

“We are having a layoff at our company – but we want to give the layoff employees a severance package that continues their salary and benefits for three months. When do we start COBRA?”

COBRA should start at the layoff and the employer pay the first three months of their COBRA premium. That keeps the employer in compliance with not only the COBRA law but also their insurance contract.

Remember the eligible employee definition in the insurance contract – a full-time employee working 30 hours a week – a employee that has been laid off is not meeting that definition. What makes the employer think they can keep them on the active coverage? Some carriers may allow this – but, if they do, now when is the COBRA event? Three months later.

FAMILY MEDICAL LEAVE ACT and COBRA

In 1993 a Federal law was put in place for employers of more than 50 employees in a 75-mile area – the Family Medical Leave Act (FMLA). This law provides employees the opportunity of leave of absence due to family medical situations. FLMA is NOT a COBRA Qualifying Event. However, an event could occur if the employee does not return to work once FMLA is exhausted.

FMLA – WHO MUST PAY

The employer must continue insurance coverage during the FMLA leave under the same conditions as before the leave including the payment arrangement. If the Employer pays 100% of the cost for an active employee, this same contribution is continued during the FMLA leave.

If the program is a contributory plan, arrangements must be made to collect the employee’s portion of the premium. But, even coverage is cancelled during FMLA because premiums are not paid, there may still be a COBRA obligation when FMLA is exhausted.

COMPLIANCE SURVIVAL

COBRA QUALIFYING EVENTS (continued)

FMLA (continued)

If coverage is cancelled for non-pay and the employee returns to work after their FMLA leave, they must be placed back on the insurance program as if they never had a gap in coverage. This includes without being subject to employment or pre-existing condition waiting periods.

If coverage is cancelled for non-pay during the 12 or 26 weeks of FMLA and the employee does not return to work, a COBRA offering may still be required but, not until the FMLA leave is exhausted. They may be eligible for COBRA continuation with a gap in coverage.

FMLA is another Federal law with compliance liabilities. Employers need to have written guidelines of how their company will handle FMLA situations - before there is a situation.

ON the JOB INJURY LEAVE

Most states have Workers Compensation laws requiring the employer to pay for medical services related to the on the job injury – and most states require the employer continue some sort of compensation level while off work. But, very few state Workers Compensation laws require benefits be continued. So when should COBRA begin?

If this is an FMLA mandated employer, they shouldn't forget that FMLA and Workers Compensation can run concurrently. FMLA would require the benefits continue for 12 weeks.

But, if not an FMLA mandated employer or when they exhaust their FMLA time, even if they are still off for an on the job injury, they must meet the definition of an eligible employee to be on the group health plan. They may still be an employee but they are not working the proper number of hours to be eligible for the insurance plan – they have had a “reduction in work hours” – use that as a COBRA qualifying event and start COBRA continuation.

LEAVE OF ABSENCE and COBRA

It is critical that employers review their Employee Handbook to ensure the leave policies described in the handbook are supported by the insurance contracts.

For example, an Employee Handbook provides for an additional 12 weeks of medical leave available after FMLA is exhausted. And yet, this is not supported by the definition of an eligible participant in the insurance contract. An employer may find themselves self-insuring any claims in the additional 12-week medical leave period.

COMPLIANCE SURVIVAL

36 - MONTH COBRA EVENTS

36 - Month Events entitle only the dependents the opportunity to continue coverage. An employee will never have a 36 month COBRA event. Those 36 month events are

- Death of the Employee
- Employee's Medicare Entitlement
- Legal Separation or Divorce
- Dependent child no longer meets dependent definition

As with most things in the COBRA law, these events are not as simple as they seem. For instance, would an *active* employee lose insurance benefits simple because they became entitled to Medicare? That would surely be an illegal program – Age Discrimination, TEFRA . . . any number of laws could be broken here!

Medicare and COBRA will be discussed later as we review the 1998 Supreme Court Ruling. We will also discuss the criteria for Medicare Entitlement to be a second qualifying event for dependents.

Another difficult area is the Legal Separation or Divorce event. Often times, an employee may simply tell the employer to drop the dependent and does not specify a reason. It is critical that the employer be “nosey” – depending on the reason, the employer may have a COBRA obligation.

Very few state still have “legal separation” as part of their divorce laws. In most states a person is married until the divorce is final – that is the COBRA qualifying event. But, for those that still Have legal separation, the COBRA event would be when the legal separation is granted. A person files for legal separation and it is approved by the court – there is the COBRA event. Then if no resends the separation, it goes into a full divorce proceeding. Some people call legal separation a “cooling off” period.

Even when a dependent is dropped at open enrollment, the employer may have a COBRA obligation – amazingly, many divorces coincide with annual open enrollments. YES, they must notify the employer – THEY DID – they said drop the spouse! The employer must know why. If they are dropping the spouse just because it is open enrollment, that is not a COBRA opportunity. If they drop the dependent because the divorce has been finalized, even if it is at open enrollment, it is still a COBRA obligation for the employer.

These legal separations and divorce situations are difficult – the employer doesn't want to be in the middle of a divorce but, they must know the reason the dependent is being dropped. Not only for COBRA law but, also for the Cafeteria Plan 125 allowable status change limitations. The privilege of paying for things with pre-tax dollars comes with rules.

COMPLIANCE SURVIVAL

36 - MONTH COBRA EVENTS

IN ANTICIPATION OF AN EVENT

The 1999 Final Regulations tried to protect employers in “not quite divorced” situations. The regulations provide an in anticipation guideline.

The primary purpose of this provision is to protect the employer when an employee terminates a spouse’s coverage in anticipation of a divorce – they drop the spouse when the *file* for divorce. *Filing* for divorce is not a COBRA qualifying event. Nor is it one of the 125 Plan allowable status changes.

If the employee is paying the “about to be ex-spouse’s” dependent premium pre-tax, through the employer 125 Plan, they cannot stop or change that pre-tax deduction until the legal separation is granted or divorce is final.

But, if the premium is not taken pre-tax, there is no law that says a person must cover their spouse on their insurance plan. Without the 125 Plan allowable status change restriction, the employee can drop a dependent anytime.

The original problems came when an employee dropped a spouse before the divorce was final but, the spouse wasn’t aware the coverage had been terminated. When the divorce was final, the spouse couldn’t be offered COBRA – they were not on the coverage the day before the divorce event. This problem really put the employer in the middle of the divorce!

PROBLEM SITUATION

Employee drops spouse August 31 when they *file* for divorce – not a COBRA event

The divorce is final in January. The ex-spouse – and their lawyer – they all want to know why no one is being offered COBRA!

“The spouse was dropped three months ago. Not active on the coverage the day before the divorce, not eligible for COBRA.”

SEE THE PROBLEM!! So the law created the “in anticipation” provision -

“ if coverage is reduced or eliminated in anticipation of a qualifying event, the elimination or reduction is disregarded in determining whether the event causes a loss of coverage.”

COMPLIANCE SURVIVAL

36 – MONTH EVENTS (continued)

IN ANTICIPATION (continued)

YES, the coverage may be dropped, but, the COBRA offering will not occur until the “true qualifying event” has occurred – the legal separation or divorce.

While, this was created to *help* the employer, this provision brings with it a number of other concerns.

- NO TIMELINE RESTRICTION - the law is silent regarding how quickly things must happen
 - no “event must occur within a certain so many months of when the coverage was dropped in anticipation of the event. In difficult divorce situations, this could leave the employer with a pending COBRA obligation for a number of months. And yet, because of different divorce timelines in different state, no “time frame” language could not be included.

- A GAP IN COVERAGE – The spouse will be dropped from the plan – they will have no coverage on the plan between when they are dropped “in anticipation” and when the COBRA event actually occurs. Two problems here.
 - the “gap” goes against the “covered on the day before the qualifying event” provision of the law
 - Coverage must be offered at the time of the COBRA event as if they had no gap in coverage – meaning, no new pre-existing condition limitation can be applied regardless of how big the gap.

- THEY RECONCILE - And, what if the employee drops the spouse in anticipation of the divorce and then they reconcile. When can the spouse be added back on the plan? Probably not until the next open enrollment or special enrollment event.

This provision may fall into the category of “looked good on paper but, in the real world . . .”

Thankfully, most employers have a Cafeteria 125 Plan and take the dependent premium pre-tax. This restricts changes in the pre-tax deduction until the allowable status change – the legal separation of when the divorce is final. So if the premiums are taken pre-tax, no “in anticipation” events can occur because of the status change restrictions.

But, if dependent premiums are not taken pre-tax, get prepared for “in anticipation” events. But before we go down that path, an employer might want to send the person back to their divorce attorney. Most divorce decrees specify that once the divorce papers are filed, coverage cannot be cancelled until the divorce is final. It may be their own divorce filing that restricts their actions.

COMPLIANCE SURVIVAL

COBRA and OTHER COVERAGE INCLUDING MEDICARE ENTITLEMENT

SUPREME COURT RULING June 98

In June 1998, the Supreme Court ruled in the Geissel vs. Moore Medical Corporation clarifying that other coverage in place prior to the election of COBRA was to be ignored when determining COBRA eligibility. Before this ruling, some employers limited COBRA offerings if the participant was already covered by another insurance plan.

Mr. Geissel was employed by Moore Medicare

The Supreme Court ruled that

“Other coverage in place PRIOR to the election of COBRA coverage should be ignored when determining COBRA eligibility.

A qualified beneficiary’s COBRA eligibility will cease when they GAIN other coverage where no pre-existing condition limitation is applicable to them.

Other coverage includes Medicare Entitlement.”

Mr. Geissel was employed by Moore Medical Corporation and covered on their employer sponsored group health plan. Mr. Geissel was also covered on his spouse’s employer plan. Mr. Geissel had what is known as “duplicate coverage”.

Mr. Geissel became very ill and was unable to work. Moore Medical Corp offered COBRA continuation – Mr. Geissel elected and paid premiums for six months. Then, Moore Medical rescinded their COBRA offering saying since he already had other coverage though his wife’s employer, that Moore Medical had no COBRA obligation.

The lower court agreed with the employer – the Court of Appeals for the Eighth Circuit also agreed. BUT, the Supreme Court heard the case to resolve a conflict among the federal circuits on whether ERISA §602(2)(D)(i) allows employers to deny COBRA continuation coverage to qualified beneficiaries who are covered under another group health plan at the time of the COBRA election.

Under ERISA §602(2)(D), COBRA coverage may cease on:

...[the date on which the qualified beneficiary first becomes, after the date of the election (i) covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, or (ii) entitled to benefits under title XVIII of the Social Security Act.

COMPLIANCE SURVIVAL

COBRA and OTHER COVERAGE (continued)

SUPREME COURT RULING June 98 (continued)

While this original court case involved other group coverage, the Supreme Court added a little something in its clarification – the other coverage definition includes Medicare Entitlement. Prior to this 1998 ruling it was thought that if an employee had already activated any part of their Medicare, they were not eligible for COBRA. But, this Supreme Court Ruling changed that.

But, to be sure there is a clear understanding of the law, let's review the definition of Medicare Entitlement – actually participating in Medicare – activating any part of Medicare benefits will make a person Medicare Entitled.

Some people may be eligible but, delay their entry into Medicare. Being eligible for Medicare has no impact on a person's COBRA eligibility. But, once they activate their Medicare, that could have a great impact – in some situations that Medicare Entitlement could be a 36 month COBRA event for the covered dependents; some days the Medicare Entitlement could cause someone to lose their eligibility for COBRA.

There have been a number of changes concerning Medicare and the COBRA law over the years. Let's take a short course in Medicare and COBRA – All You Need to Know. Some may say it is *more* than anyone would want to know but, it is knowledge you must understand to be in compliance with the COBRA law.

MEDICARE and COBRA

The interaction of Medicare and COBRA results in some rather complex and frequently misunderstood rules regarding COBRA administration. The following is a short course on Medicare's basic rules, then explains how those rules impact COBRA administration.

Medicare: The Short Course

Understanding how Medicare affects COBRA administration, requires understanding three key concepts:

1. Medicare Parts A and B;
2. Medicare entitlement: what it is and how it works; and,
3. Medicare Secondary Payer Rule

COMPLIANCE SURVIVAL

MEDICARE AND COBRA (continued)

MEDICARE PART A and B

Medicare Part A covers hospital benefits and is generally free to those individuals who qualify and enroll when first eligible. Individuals who are not fully qualified through Social Security or the Railroad Retirement Act can purchase Part A from Social Security.

Medicare Part B covers physicians, lab and x-ray, nursing, plus other eligible health care expenses. Individuals enrolling in Medicare Part B are required to pay a monthly premium.

Medicare Part D is the newest addition to Medicare benefits – the prescription drug portion. A person cannot have Medicare Part D without Parts A and B.

MEDICARE ENTITLEMENT

The concept of Medicare "entitlement" is frequently misunderstood by employers and participants. To be entitled to Medicare, the following conditions must be true:

- the individual is eligible for Medicare benefits;
- the individual has taken the steps required to enroll in the program; and
- enrollment in Medicare Part A or Part B has become effective.

One may become entitled to Medicare Part A because of his or her age, disability. A disabling condition normally has a timeline of 29 months before a person is Medicare eligible under the age of 65. Two disabling conditions provide Medicare disability earlier than other conditions - End Stage Renal Disease – ESRD – kidney dialysis or ALS – Lou Gehrig’s Disease. For those two conditions, Medicare benefits will begin 5 months from the date of disability.

For “age” participants, entitlement is automatic if the individual has already applied to receive monthly retirement benefits from Social Security or the Railroad Retirement Board. If the individual has not applied for retirement benefits, an application must be filed to receive Part A benefits. But, do not confuse “automatic” with “always have it” – a person could delay their entry in to Medicare. And with the Social Security Benefit being pushed back, many people or doing just that. Never assume every 65 year old has Medicare benefits.

COMPLIANCE SURVIVAL

MEDICARE AND COBRA (continued)

ENTITLEMENT DUE TO AGE

An eligible individual is entitled to Part A benefits if he or she has attained age 65 and files the appropriate application, if necessary. Entitlement based on age begins on the first of the month in which the individual has met his or her requirements for entitlement. If the individual applies for Social Security income benefits before their 65th birthday, the entitlement date is the first of the month that he or she attains age 65. If the birthday falls on the first of the month, the Medicare entitlement date is the first of the previous month.

While eligible at the same time, they must apply and pay for Part B and D.

ENTITLEMENT DUE TO DISABILITY

An individual is entitled to Medicare Part A benefits if he or she is under age 65, and has been entitled to disability income benefits under Social Security or the Railroad Retirement Act for more than 24 months. Because eligibility to receive disability income payments requires a 5-month waiting period, an individual will have to wait a total of 29 months before receiving Medicare benefits due to a disability under age 65.

ENTITLEMENT DUE TO END-STAGE RENAL DISEASE (ESRD) or ALS

Individuals who have ESRD-irreversible and permanent kidney impairment that requires regular dialysis or a kidney transplant-are entitled to Part A benefits. They must also file the required application and satisfy any required waiting period. An ALS disabling condition affords the same entitlement. But, these two conditions follow a different timeline – the Medicare benefits are eligible 5 months from the Social Security date of disability.

ENTITLEMENT TO MEDICARE PART B and D

Entitlement in Medicare Part B optional but, is available if the individual enrolls in Medicare Part A and B, lives in the United States, and does not decline the automatic enrollment that occurs at the time that they enroll in Medicare Part A. While for most participants Medicare Part A is provided at no charge, there is a premium associated with Part B.

Part D, the prescription drug benefit, requires both Part A and B be activated. Normally there is a premium tied to the Part D benefit.

COMPLIANCE SURVIVAL

MEDICARE AND COBRA (continued)

Delaying enrollment in any Part of Medicare could limit a person's opportunity to obtain coverage. Medicare has very strict rules enrollment rules. Participants should discuss these restrictions with Social Security – not the employer.

MEDICARE SECONDARY PAYER (MSP) RULES

These rules generally prohibit a group health plan from taking Medicare coverage into account, and dictate the order of claim paying responsibility for medical expenses when both a group health plan and Medicare insure a person. The MSP rules cover Medicare entitlement based on age, disability, and ESRD:

- Businesses with fewer than 20 employees are exempt from age-based MSP rules that require a group health plan to be the primary claim payer. The 20-employee test is based on each working day in at least 20 weeks during either the current or the preceding calendar year. This test is run as of the date the individual receives medical services.
- Businesses with fewer than 100 employees on at least 50% of its regular business days during the previous calendar year are exempt from disability-based MSP rules that require a group health plan to be the primary claim payer.
- When Medicare entitlement is based on ESRD or ALS, Medicare is usually considered the secondary payer for up to the first 30 months of coverage. However, if an individual is first entitled to Medicare based on age or disability and then later becomes eligible for ALS or ESRD-based Medicare, Medicare will remain the primary payer of benefits.

The purpose of the MSP rules is to shift the financial burden for medical expenses to business and away from the federal government. But again, MSP rule questions are something the claim payer should answer. There is a very strict order of claim payment depending on the size of the employer and the medical diagnosis and expense – an employer should never offer an opinion or advice in these situations. That is the claim payer's job.

MEDICARE ENTITLEMENT AS A COBRA QUALIFYING EVENT – VERY RARE!

The COBRA law states that when an employee loses health coverage because of a Medicare entitlement, it is considered a qualifying event for the employee's covered spouse and dependent children. However, because of Medicare's Secondary Payer Rules, which generally prohibit an employer's group health plan from taking Medicare entitlement into account or terminating coverage, this situation will rarely result in an initial COBRA qualifying event.

COMPLIANCE SURVIVAL

MEDICARE ENTITLEMENT MAY CAUSE A LOSS OF COBRA ELIGIBILITY

When a qualified beneficiary's Medicare entitlement occurs after he elects COBRA, the plan may terminate his COBRA coverage on the date of the Medicare entitlement. They were on COBRA coverage and GAINED other coverage – clarified in the 1998 Supreme Court Ruling.

MEDICARE ENTITLEMENT AS A SECOND QUALIFYING EVENT – EVEN MORE RARE!

Again, because of the MSP rules, an employee or former employee's Medicare entitlement will rarely be a second qualifying event extending COBRA coverage for a spouse or child.

A 2004 IRS memorandum specified that a second qualifying event under COBRA must meet the same basic requirements as an initial qualifying event; the event must cause a loss of coverage under the health plan, had it occurred while the employee or dependent was still covered under the plan before COBRA coverage went into effect.

Three Conditions Must Be Satisfied for a Second Qualifying Event:

- Spouse or Dependent must be QB in connection with an 18 month event
- Spouse or Dependent must still be a QB at the time the 36 month event occurs
- The 36 month event must be a Qualifying Event –
 - the dependent must lose coverage because of the event

TEST QUESTION:

- **Background**
 - **Employee is covering himself and his spouse on his employer sponsored group health plan**
 - **The Employee quits his job**
 - **Employee and spouse activate their 18 month COBRA opportunity**
- **In month 16 of their 18 months of COBRA, the ex-employee becomes entitled to Medicare and loses their COBRA eligibility**
- **Is this a second qualifying event that would allow the spouse 36 months of COBRA continuation?**

COMPLIANCE SURVIVAL

MEDICARE AND COBRA (continued)

To answer this question we must go back to that 2004 IRS memorandum and the three criteria that must be met for there to be a second qualifying event –

- Dependent must be a Qualified Beneficiary in connection with an 18 month event – on the active coverage before the original 18 month event – the spouse was
- Dependent must still be a Qualified Beneficiary at the time the 36 month event occurs – on the COBRA when the Medicare Entitlement event occurred – the spouse was
- The 36 month event must be a Qualifying Event for the dependent –
 - the dependent didn't lose coverage because of the ex-employee's Medicare Entitlement – only the ex-employee lost COBRA eligibility. The spouse was a qualified beneficiary on the COBRA coverage – they have their own right to COBRA continuation with or without the original employee. The spouse did not have a second COBRA qualifying event. The spouse is eligible for only the remainder of the original 18 months of COBRA.
 - In our test question, the Medicare Entitlement for the ex-employee happened in the 16 month of their 18 months of COBRA – the spouse has two months of COBRA continuation remaining.

WHAT HAPPENS WHEN MEDICARE ENTITLEMENT IS FOLLOWED BY A COBRA EVENT?

When an employee is entitled to Medicare, then loses coverage due to termination or reduction of hours within 18 months of their Medicare Entitlement Date, the employee's covered spouse or dependent child may extend coverage under COBRA up to a maximum of 36 months from the date of the employee's Medicare Entitlement. The employee, however, is restricted to a maximum of 18 months.

This is one of the most unusual provisions of the COBRA law – but, we must review the law's history to find the logic in this provision.

Until the Supreme Court Ruling in 1998 where it was clarified that Medicare Entitlement in place prior to the election of COBRA is to be ignored, if a person was covered by Medicare they were not offered COBRA – you never saw Medicare and COBRA in the same sentence. Let's look at an example to explain the unusual COBRA provision of dependents eligible for 36 months of COBRA calculated from the Medicare Entitlement Date.

COMPLIANCE SURVIVAL

MEDICARE AND COBRA (continued)

TEST QUESTION:

- **BACKGROUND**
 - **Employee and Dependent on Group Health Plan**
 - **Employee activates their Medicare effective January 1, 2011**
 - **Employee terminates employment October 31, 2011**

- **Employee – eligible for how long on COBRA?**
- **Dependent – eligible for how long on COBRA?**

Had this situation occurred before the Supreme Court Ruling of 1998, the employee would have had no COBRA available to them but, the dependents, since Medicare Entitlement was followed by a COBRA event, would be eligible for 36 months of COBRA continuation calculated from the Medicare Entitlement Date. Not the COBRA event date – the Medicare Entitlement date

Let's answer the test question as if this situation occurred before 1998.

- The employer would have no COBRA available
- The dependents would have 36 months of COBRA calculated from the Medicare Entitlement date.

But, then the Supreme Court ruled we must ignore other coverage in place prior to the election of COBRA – even if that other coverage is Medicare Entitlement. Now let's answer the test question by today's rules.

- The employer would have 18 months of COBRA continuation calculated from the COBRA event date – November 1, 2011
- The dependents would have 36 months of COBRA calculated from the Medicare Entitlement date – January 1, 2011 – they are eligible for COBRA continuation for 26 months – November 1, 2011 to December 31, 2013.

If Medicare Entitlement is followed by a COBRA event occurring more than 18 months from the Medicare Entitlement date, both the employee and dependents are eligible for only 18 months of COBRA continuation.

COMPLIANCE SURVIVAL

MEDICARE and COBRA (continued)

ANOTHER TEST QUESTION:

We have an employee covering his spouse on our group plan. He has turned 65 and has Medicare. He is still working but, he wants to drop the insurance and just have Medicare and a Medicare Supplement. I was trying to see how long the spouse could have COBRA – I thought it would just be 18 months but, I see that “Medicare Entitlement” is a 36 month COBRA event. Is that right?

DON'T SEND THAT COBRA LETTER YET! Let's set a few COBRA basics first before we get into the details of this question.

Basic COBRA Rule #1 – a COBRA event is a specified event noted in the law that CAUSES someone to lose insurance benefits. Not just the event happening – them losing insurance because of the event – THAT is a COBRA Qualifying Event.

Having an event doesn't necessarily mean that is a COBRA event. Example: Reduction in work hours is listed in the law as a COBRA Qualifying Event – the contract specifies that eligibility for the group health plan is a full-time employee working a minimum of 30 hours a week. An employee working 40 hours a week cuts their hours to 32 – YES, a reduction in work hours but, that didn't cause anyone to lose insurance benefits – no COBRA qualifying event. The loss of coverage must be a direct result of the event.

Now with that clarification on the table, let's look at what really happened in the test question.

An ACTIVE employee has become Medicare Entitled – he activated some part of his Medicare. Now he would like to drop his group insurance benefit and go with just Medicare and a Medicare Supplement. Problem – his spouse is not eligible for Medicare yet. But, when he dropped his group insurance, the spouse lost coverage. Is this a COBRA event for the spouse?

Remember our rule – a COBRA event must CAUSE someone to lose coverage. He is still an active employee – he is still eligible for the active group health plan. When he became Medicare Entitled – he VOLUNTARILY DROPPED his group coverage. Granted, he was doing that because he became entitled to Medicare but, that Medicare Entitlement did not CAUSE him to lose his employer sponsored group plan – he voluntarily dropped it. Just like someone that drops coverage at open enrollment – THAT isn't a COBRA event.

The problem: a dependent can't be on ACTIVE group coverage without the employee. The employee voluntarily dropped the group plan – it is dropped for the employee and dependents. And again, that is not a COBRA continuation opportunity for any dependent.

COMPLIANCE SURVIVAL

MEDICARE AND COBRA (continued)

Not enrolling in Medicare before COBRA terminates can have negative consequences

Although qualified beneficiaries are not required to enroll in Medicare Part A or B, it may be in their best interest to do so before COBRA coverage terminates for the following reasons:

- If an individual does not elect Medicare Part A and B while covered or during the 8-month special enrollment period following the loss of group health coverage, the monthly premium cost will increase an additional 10% for every 12-month period past the initial enrollment period.
- If an individual does not enroll in Medicare Part A or B coverage before the end of the 8-month special open enrollment period, he or she will not be able to enroll until the next regular Medicare annual open enrollment period (January 1, through March 31 each year) and their coverage entitlement date will not begin until July 1 of that same year. Consequently, an individual who loses COBRA coverage may have to wait up to 15 months before Medicare Part A or B becomes effective. For example, if an individual is eligible but has not enrolled in Medicare Part A or B and loses COBRA coverage on April 1, Medicare coverage would not be effective until July 1 of the following year.
- If the individual delays their entry into Medicare because they have group insurance, when they lose that group insurance it MAY trigger a special Medicare enrollment opportunity with no premium penalties.
- However, for Part D benefits, the group coverage must be “creditable coverage” as defined in the Medicare Part D law – that is a plan with no more than a \$250 deductible on prescription benefits. If the individual has NON-creditable Part D coverage, the Part D law says premium will increase 1% per month for every month enrollment is delayed unless the individual is coming off of a creditable Part D group plan.

Once again, individuals should discuss their specific Medicare eligibility provisions with their Social Security office.

IF AN INDIVIDUAL IS COVERED BY BOTH MEDICARE AND COBRA, WHICH PLAN IS THE PRIMARY CLAIM PAYER?

Again, primary and secondary payer questions should be answered by the claim payer. But, in general, the MSP rules state that when Medicare entitlement is based on age or disability, Medicare is considered the primary claim payer for individuals covered under COBRA. However, COBRA does not change the MSP rules for persons entitled to Medicare entitlement due to ESRD or ALS. With the exception of ESRD and ALS, Medicare always pays primary to non-active coverage – COBRA, Retiree Plans . . .

COMPLIANCE SURVIVAL

EXTENSIONS OF COBRA COVERAGE

Situations may occur that extend COBRA continuation coverage past the original 18 – month period. There are two types of extensions:

- Social Security Disability Extension – allows eligible participants and other family members up to an 11-month extension of their COBRA coverage
- Second Qualifying Event – an additional COBRA event occurs while participants are on COBRA continuation. The second events allow qualified beneficiaries dependents to extend their COBRA coverage up to 36 months.

COBRA 11-MONTH SOCIAL SECURITY DISABILITY EXTENTION

The COBRA law provides participants that have received Social Security Disability Certification the opportunity to extend their COBRA continuation for an additional 11 months after their original 18 months continuation has expired. While the original COBRA law of 1985 did not include this provision, an amendment was quickly added to provide an extension of benefits that would coordinate with the under age 65 Medicare coverage available through Social Security. In 1997, the Health Insurance Portability and Accountability Law expanded the eligibility of this coverage.

To better understand the reasoning of this extension of COBRA coverage, we must look at both the COBRA and Social Security Disability timelines. Let's first discuss the eligibility and premium requirements of the extension.

- The COBRA continuant's date of Social Security Disability must be before the COBRA coverage begins or within the first 60 days of COBRA coverage
- Social Security Disability Certification must be received before the original 18-month COBRA continuation is exhausted
- Notice of Social Security Disability Certification must be given to the employer or their elected COBRA administrator within 60 days of receipt
- Should Social Security Disability eligibility cease, the employer or their COBRA administrator should be notified within 60 days
- During the 11-month extension, the COBRA premium MAY be increase to 150% of the active employee premium amount

COMPLIANCE SURVIVAL

EXTENSIONS OF COBRA COVERAGE (continued)

COBRA 11-MONTH DISABILITY EXTENTION (continued)

The process of obtaining Social Security Disability Certification is a tedious and exhausting process that often takes 3 to 12 months. But, once approved, the participant receives their Social Security Disability Certification letter that identifies important dates.

- Date of Disability
- Date of Social Security Disability Income eligibility
- Date of Social Security Disability Insurance (Medicare under age 65)

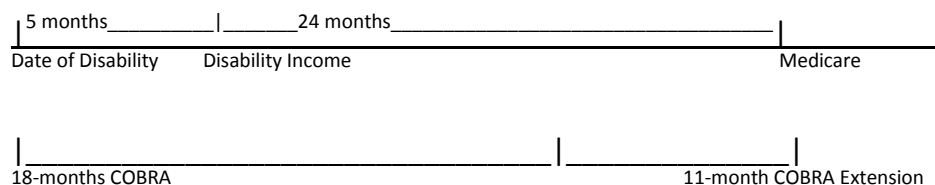
Date of Disability – this begins the Social Security Disability clock. This is the date Social Security declares the participant was disabled. Not the date of the letter but, the “you were disabled as of this date” date. For COBRA extension eligibility, the date of disability must be before COBRA coverage begins or within the first 60 days of COBRA coverage.

Date of Social Security Disability Income – there is a 5-month Disability Income waiting period calculated from the date of disability. This date has no relevance to the 11-month COBRA extension eligibility but, it begins the Social Security Disability benefit.

Date of Social Security Disability Insurance (Medicare under the age of 65) - for most disabling conditions (end stage renal disease and ALS have a shorter waiting period) there is a 24-month wait for Medicare Insurance benefits. This waiting period begins when Social Security disability benefits begin – on the Social Security Disability Income Date.

From the disability date, there is a 29-month wait before Medicare Disability Insurance begins.

Let’s look at how the COBRA timeline compares. A person is unable to work because of their medical condition. This is an 18-month COBRA Qualifying Event. Let’s assume the person’s date of disability and COBRA coverage begins on the same day. At the end of the 18-months of COBRA coverage, the person still has eleven more months before their Medicare Insurance begins. Thus, the reason for the 11-month extension of COBRA coverage – to fill the gap between original COBRA ending and Medicare Benefits beginning.



COMPLIANCE SURVIVAL

EXTENSIONS OF COBRA COVERAGE (continued)

COBRA 11-MONTH DISABILITY EXTENTION (continued)

Social Security Disability Worksheet

<i>CRITERIA REQUIREMENT</i>	<i>YES</i>	<i>NO</i>
<i>Social Security Certified Disabled Date –(date of disability) before or within 60 days of the COBRA begin date</i>		
<i>Certification received before the end of the original 18 months of Federal COBRA Continuation</i>		
<i>Certification provide to the Employer or COBRA Administrator within 60 days of receipt</i>		

Participants must be able to answer YES to each criteria to be eligible for the 11- month extension of COBRA Continuation

SECOND QUALIFYING EVENTS

At times, COBRA participants may experience another COBRA qualifying event while they are already on COBRA. Only certain qualified beneficiaries (dependents on coverage prior to the original qualifying event) are eligible for second qualifying event extensions. Only 36-month qualifying events result in second qualifying events. 18-month events cannot be stacked – or considered a second event.

Three Conditions Must Be Satisfied for a Second Qualifying Event:

- Spouse or Dependent must be a qualified beneficiary in connection with an 18 month event
- Spouse or Dependent must still be a qualified beneficiary at the time the 36 month event occurs
- The 36 month event must be a Qualifying Event for the dependent –
 - the dependent must lose coverage because of the event

For example, an employee and his spouse experience an 18 month COBRA event and elect COBRA together. After 12 months on COBRA, they divorce. Divorce is a 36 month qualifying event – but this event occurred while they were on COBRA. The divorce is a second qualifying event for the spouse. She will now be eligible for up to 36 months of COBRA continuation – not an additional 36 months of coverage – 36 months of COBRA calculated from the original qualifying event date. They had been on COBRA for 12 months – divorce – the spouse will be eligible for 24 more months of COBRA continuation. The ex-employee will have only 6 more months of continuation – the remainder of the original 18 months.

COMPLIANCE SURVIVAL

EXTENSIONS OF COBRA COVERAGE (continued)

SECOND QUALIFYING EVENTS (continued)

Look at it this way – if the employee covering their spouse had still be working for the company when the divorce was final, wouldn't the spouse have been eligible for 36 months of COBRA? The fact that the divorce occurs while they are on COBRA, does change the fact that the spouse will have their opportunity for 36 months of COBRA.

But, the dependent must be a qualified beneficiary to be eligible for second qualifying events. They must have been on the active coverage before the original event.

NON-Qualified Beneficiary

A single woman covered on the employer group health plan quits and activates her COBRA continuation. While on COBRA continuation, she marries.

- **1st question – can she add her new husband to her COBRA coverage?**
 - **Can an active employee that marries add their new spouse to their group coverage? If yes, then so can a COBRA participant by the same rules.**
 - **Remember, anything an active employee can do a COBRA participant can do**

- **BUT, this spouse was not on the active coverage, they were added to COBRA after it began. YES, they can have COBRA continuation but, only as a NON-qualified beneficiary – meaning they**
 - **Do not have their own right to COBRA continuation – they will only have COBRA as long as the original COBRA participant has COBRA**
 - **They are not eligible for second qualifying events**

- **While still on COBRA, this couple divorces – short marriage**
 - **The NON-qualified beneficiary spouse will lose their COBRA coverage – they are not eligible for second qualifying events – they cannot have COBRA continuation without the original COBRA participant**

When that phone rings and some says

“My husband and I are on COBRA – we are getting a divorce – how long can my spouse keep COBRA?”

No one can properly answer that question until they determine if the spouse is a qualified or non-qualified beneficiary. Is this a new spouse added to COBRA after it began – or an old spouse added to COBRA at open enrollment? A wrong answer could create a compliance liability.

COMPLIANCE SURVIVAL

BANKRUPTCY

A bankruptcy proceeding under Title 11 constitutes a qualifying event if it causes certain qualified beneficiaries to lose group health plan coverage. In these instances, the definition of qualified beneficiary is expanded to include covered retirees, employees and dependents with a substantial elimination of coverage.

In this context, a loss of coverage includes a substantial elimination of coverage within one year before or after the date the bankruptcy proceeding was commenced.

COBRA participants may be eligible for continuation as long as the employer sponsored plan is active. Courts have held that circumstances resulting in the termination of a plan are sufficient to terminate an employer's COBRA obligations. For example, cessation of an employer's legal existence, with no successor employer, has been held to terminate an employer's group health plan and negate any COBRA continuation obligation.

RETIREE PLANS in EMPLOYER BANKRUPTCY – EXTENDED BENEFITS

There is a very special provision of the COBRA law for retirees on a plan when a company files Title 11 bankruptcy.

- The retiree is entitled to COBRA coverage for life.
- The retiree's spouse and dependent children are entitled to COBRA continuation for the life of the retiree and, if they survive the retiree's death for 36 months after the retiree's death.
- If the retiree is not living when the bankruptcy event occurs, but, the retiree's surviving spouse is living and covered by the group health plan, that surviving spouse is entitled to COBRA continuation for life

Again, this obligation for the extended coverage is only applicable if the employer continues to maintain and employer sponsored health plan.

LOSE COBRA ELIGIBILITY IF GAIN NEW COVERAGE EXCEPTION IN BANKRUPTCY

COBRA eligibility is normally lost if, after electing COBRA continuation, a participant gains new coverage or Medicare Entitlement. But, this is not so in bankruptcy situations. Retirees, their spouses and dependent children who are entitled to COBRA coverage on account of the substantial elimination of coverage within one year before or after a bankruptcy proceeding are exempt from this loss of eligibility upon gaining new coverage or Medicare Entitlement.

COMPLIANCE SURVIVAL

MILITARY LEAVE and COBRA

To understand an employer's COBRA liability involving employees and military service, one must compare the COBRA law to the Uniformed Service Employment and Reemployment Rights Act of 1994 (USERRA). USERRA was introduced as a result of the Gulf War and created new health plan continuation coverage rights for persons who are "absent from their position of employment by reason of service in the uniformed services."

Of course, COBRA would establish some of the same rights under a reduction of work hours qualifying event. However, USERRA continuation affords the employee and their dependents greater rights than COBRA continuation. Should an employer choose to designate a COBRA qualifying event, the maximum continuation period is not extended – USERRA and COBRA continuation run concurrently.

USERRA – It's the Same and It's Different

SAME AS COBRA – both Health Plans eligible for continuation and the 18-month coverage period – however the Veterans' Benefits Improvement Act of 2004 extended USERRA maximum coverage period from 18 to 24 months those electing coverage after December 10, 2004. Now, we have to say this is another difference.

COBRA and USERRA DIFFERENCES

- USERRA applies to ALL employers – no small employer, government or church plan exceptions
- Premium – 102% except for a person who performs service in the uniformed services for less than 31 days – in these instances the premium cannot exceed the employee's share - – the same as they were paying as an active employee
- Termination of Coverage – only ONE instance allows termination prior to the maximum 24-month continuation period – "*the day after the date on which the person fails to apply for or return to a position of employment.*" Return to work deadlines are specified in the USERRA law and range from 8 hours to 90 days after military leave ends
- Coverage cannot be terminated for gaining other coverage or nonpayment of premium. Actually USERRA is silent regarding premium payments – silence in the law translates as no allowable action
- USERRA requires an "election" of continuation. Technically, COBRA does not. While dependents can receive continuation rights through the employee, they have no independent election rights under USERRA
- USERRA has no formal "notice" requirement or timeline – continuation rights must be explained in the summary plan document. The employer should inform the employee of their USERRA rights when they are notified of the military leave

COMPLIANCE SURVIVAL

MILITARY LEAVE and COBRA (continued)

COBRA and USERRA Differences (continued)

- USERRA does not require an extension of the 18-month coverage period for any reason
- Notice – COBRA requires notice be provided. The notice must include explanation of independent election rights, payment grace periods and reasons coverage may be terminated.

You can see there are a number of differences between COBRA and USERRA. But there are still questions unanswered.

- Is the employer required to identify the areas where USERRA benefits are greater?
 - Premium Payments – since USERRA provides no premium payment guidelines, can coverage be cancelled due to nonpayment?
 - Should the employer sponsored plan cease to exist, can USERRA coverage end?

Obviously, one would assume that USERRA's silence in some areas is not meant to require continuation beyond reasonable limits. A recommendation is to follow COBRA premium payment and coverage guidelines established in the COBRA law.

BUSINESS REORGANIZATIONS - Mergers and Acquisitions

The 1999 Proposed Regulations gave the first official guidelines for buy/sell situations – prior to this, guidance came from precedent setting court cases. The 2001 Final Regulations set everything in INK and provided rules for mergers and acquisitions AFTER January 1, 2002.

Simple Explanation of the Law – no one will lose their COBRA opportunity because of a business reorganization, merger or buy out.

The law allow for two options –

- The 2 lawyers discuss it and decide who will offer COBRA - that hardly ever happens. OR
- DEFAULT
 - If the seller still sponsors an insurance plan for ANY employee - then the current COBRA participants and those losing insurance benefits because of the merger or buyout, will remain the COBRA obligation of the seller
 - If the seller no longer exists or no longer sponsors a group health plan, then the BUYER bought not only the company, but also any of the current COBRA participants and has a COBRA obligation to anyone that loses insurance benefits because of the buyout or merger.

COMPLIANCE SURVIVAL

COBRA TIME TABLE

The COBRA law identifies a timeline for notifications and payments.

60 days - Employee tells Employer

30 days - Employer Tells Administrator

14 days - Notice is provided

60 days - Election Period

45 days - Initial Payment is sent

30 days - Subsequent payments sent

NOTIFICATION

Employee Notifies Employer

In events where an employer may not be aware (legal separation, divorce, or dependent no longer eligible) the employee or qualified beneficiary has **60 days** to notify the employer of the event

Employer Notifies Administrator

If employer has outsourced their COBRA notification obligation, the Employer has **30 days** to notify the Administrator

Notice is Sent

COBRA Continuation Notification must be **provided** the latter of - **14 days** of the coverage end date or 14 days of notification – if the COBRA Administrator and the Plan Administrator are the same, the 2004 Regulations provide for a **44 day** timeline to provide the COBRA Notice

ELECTION AND PAYMENT

Qualified Beneficiary Elects Coverage

The election period ends **60 days** from the latter of, the notice the notice is **provided or coverage ends**. Election must be **sent** by the end of the election period

Initial Payment Sent

The Initial Payment for COBRA coverage must be **sent** within **45 days** of the election and must bring the qualified beneficiaries to a current paid status

Subsequent Payments

Subsequent payments must be **sent** within **30 days** of the due date

COMPLIANCE SURVIVAL

TRADE ACT 2002 and 2010

The 2002 Trade Act provides COBRA tax credit and new second election periods for certain displaced workers. On August 6, 2002, President Bush signed into law the Trade Act which expands COBRA benefits available to

- **workers displaced by import competition or shift of production to other countries.**

This provision is simply an expansion of the 1974 Trade Adjustment Assistance provisions that were scheduled to expire September 30, 2001 – extended to September 30, 2007 – and again through 2011.

GOVERNMENT SUBSIDY

The Act provides eligible participants with a 65% government subsidy – increased to 80% in 2010 (tax credit for participants and their families) for certain types of medical premiums including COBRA premiums. The tax credit are available to eligible participants on a month-by-month basis with the following limitations

- The taxpayer must be an eligible individual
- The taxpayer is paying premiums for qualified health insurance
- The taxpayer and family members do not have other specified coverage
- The taxpayer is not in prison

ELIGIBILITY - An individual is eligible for the tax credit if

- Eligible for Trade Adjustment Assistance
- A PBGC pension recipient (an individual at least 55 years of age and receiving pension benefits paid by the Pension Benefit Guaranty Corporation).

QUALIFIED HEALTH PLANS - The ACT specifies qualified health plans eligible

- COBRA or other continuation
- NOT for Flex Plan or HIPAA exempt plans

OTHER SPECIFIED COVERAGE EXEMPTIONS - The credit is NOT available for taxpayers who have other specified coverage including

- Other coverage for taxpayer or spouse if an employer or former employer pays at least 50% of the cost of the coverage – NOTE: coverage paid for by the taxpayer on a pre-tax basis under a cafeteria plan, is considered employer-paid!
- • Medicare or Medicaid

COMPLIANCE SURVIVAL

TRADE ACT 2002 and 2010 (continued)

EFFECTIVE DATE

Tax Credit provision is effective for taxable years beginning after December 31, 2001. The actual credit was not eligible for 90 days after the date of the enactment (August 6, 2002). TRUE first credit month – December 1, 2002 – but, as mentioned earlier, this tax credit appears to have an eternal extension – currently, the 80% tax credits are available through 2011.

SECOND ELECTION PERIOD

The Act provides a second 60-day election period for eligible workers not already electing COBRA. This second election period is restricted to

- Those eligible for trade adjustment assistance and job loss eligible under the Trade Act
- Failed to elect COBRA during the regular COBRA election period
- Coverage elected during the new second election period commences on the first day of the NEW second election period
 - no retro-active coverage between initial loss and first day of second election period – will COBRA still end 18, 29 or 36 months from original loss?
- Loss of coverage to the first day of the second election period will not count toward the HIPAA pre-existing credit 63-day “gap”

COMPLIANCE SURVIVAL

COBRA COVERAGE ENDS

Qualified Beneficiaries are not eligible to continue their COBRA coverage the earliest of the following:

- The time period expires (18, 29 or 36 months)
- Timely payment is not sent
- The date on which the qualified beneficiary GAINS (becomes covered) under another health plan (including being entitled to Medicare) that does not contain a pre-existing condition limitation applicable to the COBRA participant
- The employer ceases to maintain an employer sponsored health plan for ANY employees

COBRA PREMIUMS

Employers are allowed to charge up to 102% of the cost of non-COBRA participant coverage – up to 150% during the SS Disability extension.

This calculation is not as simple as it appears. For instance, self-insured plan costs include more than the contribution to the expected claims fund; stop loss premium, administrative costs . . . The plan must maintain actuarial substantiation of how the premiums were calculated.

RATING GUIDELINE

The only rating guideline provided in the law is if one person is continuing.

- One continuing participant, whether an employee or dependent, will be charged the applicable individual cost

If two or more participants are continuing, they are charged according to the plans pricing structure. Rating questions always arise when two or more children are continuing. The law provides no rating guideline here – the rate is established by the carrier or Plan.

- Set up each child on their own membership and charge each one the individual rate
- Establish one child as the member and one as the dependent and charge the two-person rate
- Begin with the family or employee and children rate – minus out the employee cost and charge the dependent add-on rate

In the absence of rating guidelines, all or any of the above are legal – consistency will be the rule – the same rate for each like situation.

COMPLIANCE SURVIVAL

COBRA PREMIUMS (continued)

LESS THAN SIGNIFICANTLY SHORT PAYMENTS

The 1999 Proposed COBRA Regulations provided a provision for *less than significantly short* COBRA payments. However, it was not until the 2001 Final Regulations that this term was defined – the lesser of 10% or \$50.

If a COBRA payment is received meeting this “lesser of 10% up to \$50” criteria, the law gives two options:

- Waive the Shortage – actually pay it for them; the carrier will expect 100% premium payment; or
- Bill for the Shortage – should the employer elect to bill, they must provide the participant an additional 30 day grace period to pay the shortage amount

Controversy continues as to whether coverage can be cancelled if the less than significantly short payment is not received. Many contend that the term “less than significantly short” was purposeful – the majority of the payment was received. Is this really a “waive it now or waive it later” provision?

NSF PAYMENTS

A more concerning problem is the entire payment being a NSF check. The COBRA law is silent regarding NSF payments. This leaves the situation to the guidelines of each State’s NSF

However, “good” payment must be made by the payment grace period established in the law.

What can the administrator do if they are notified the payment is NSF? All depends on when the administrator is notified that the check is NSF.

- NSF notification within the payment grace period – the participant has until the end of that grace period to make that a good payment
- NSF notification past the payment grace period – the participant must make good payment within the grace period. If notice that the payment is NSF doesn’t occur until after the payment grace period, the participant has no opportunity to make this a good payment. Coverage is cancelled retro-active to the coverage of last good payment

In either case, the administrator is NOT required to notify the participant their payment is NSF – the bank will do that.

COMPLIANCE SURVIVAL

COBRA PREMIUMS (continued)

COBRA RATE CHANGES

QUESTION: The employer's anniversary date is May, but the carrier has notified them of an off-cycle rate increase effective November 1. The employer sends a notice to the COBRA participants of this change. They have two COBRA participants on the Plan. Someone said you cannot increase the COBRA rates for 12 months! The people started on COBRA started June 2010 – does that mean their rate cannot be increased for 12 months? Does the employer have to pay the difference?

ANSWER: The COBRA law provides very specific COBRA premium rules, especially regarding limitations on rate changes. The law requires employers to establish a 12-month determination period, (normally anniversary date to anniversary date) during which the rates cannot increase except for changes in coverage or the allowed 102% to 150% increase for Social Security Disability Extensions. This determination period is the same for continuing participants – it is not determined by their *specific* COBRA start date. So, this is not to say the specific COBRA participant's COBRA rate will remain the same for 12 months – they will be charged the applicable premium required for their coverage (the same required for active employees).

Example – the group's anniversary date is May 1. The employer's 12-month determination period for all COBRA participants is May 1, 2011 to April 30, 2012 and May 1, 2012 to April 30, 2013. An employee leaving a company and electing COBRA in January 2012 will pay the rate from the determination period of May 1, 2011 to April 30, 2012.

They do not have a personal determination period of January 1 2012 to December 31, 2013. No, No. If the rates increase on the next anniversary date, May 1, 2012, the rate will increase for all COBRA participants – regardless of their COBRA begin date.

So to say the COBRA participant has a 12 month rate guarantee is correct – but, it is not specific to THEIR COBRA start date – it is the 12 month determination period of the employer's plan.

The determination period is "computed and fixed" and cannot be changed during the determination period except for changes in coverage. This assumes the employer charges the maximum 102% or 150% premium. If charging less than the allowable amount, the employer is allowed to adjust rates to the maximum at any time during the determination period.

COMPLIANCE SURVIVAL

COBRA PREMIUMS (continued)

COBRA RATE CHANGES (continued)

Example – The 2% administrative fee is an optional fee – many employers do not charge that. The 12 month determination period is set at May 1, 2011 to April 30, 2012. The company is not charging their COBRA participants the 2% administrative fee. In January 2012, they hire a new CFO that is a firm believer in “get every penny!” Can they increase the current COBRA participant’s rate before May 2012?

YES – the administrator is charging less than the maximum amount allowed in the law – adjustments can be made at any time up to the maximum allowed in the law. BUT, once they begin charging the maximum, they cannot increase the cost again (assuming no change in benefits or eligibility) until the next 12 month determination period.

But, if the employer is already charging the maximum and the carrier does an off-cycle rate increase with no change in benefits in January, the employer will not be allowed to pass the rate increase on to the current COBRA participants, as their rate can only increase once in the 12-month determination period. Thus, the employer will be subsidizing their COBRA premiums until the end of the current determination period.

COBRA PENALTIES

There are many penalties for noncompliance with the COBRA law – IRS excise tax, ERISA penalty, claim payments, damages and attorney fees. Failure to provide notice of COBRA continuation options can result in a \$100 per day (\$200 two or more QB) excise tax. The IRS may waive the penalty if the employer gives notification within 30 days of notice of violation.

ERISA Penalties can be assessed at \$110 per day of non-compliance, per qualified beneficiary and per violation.

Problems don’t have to come from a complaint. They may be discovered in a random compliance audit.

Normally, employers will not find themselves in court for a COBRA violation unless there are claims costing more than the COBRA premium owed. Claim Cost, Damages and Attorney Fees can add to the non-compliance expense. The goal is to make the person whole.

COMPLIANCE SURVIVAL

COBRA COMPLIANCE COMMUNICATIONS

The COBRA law requires employees and eligible dependents be notified of the opportunities provided under these laws upon employment and coverage becoming effective as well as when coverage is lost. Initial Notices protect the employer by helping them explain the “rules of the game” to employees and dependents. Failure to send any one of the communications properly can result in non-compliance penalties, fines and litigation.

The Department of Labor’s 2004 Final COBRA Regulations primarily provide a check list of information required to be in the COBRA General Notice (originally the Initial Notice) and Event Notice. Model COBRA General and Election notices can be found on the DOL’s website.

www.dol.gov/ebsa

Click on Compliance Assistance – then look for the COBRA section

The following are the required COBRA notices:

- General (or Initial) Notice. This notice provides general information to plan participants regarding COBRA and the plan’s procedures. It must be provided within 90 days after plan coverage begins and must be written to be understood by the average plan participant. It may be provided as part of a Summary Plan Description. The COBRA notice rules specify the required content (see below) and also provide a model notice.
- Election Notice. The election notice is the most important notice for participants and beneficiaries who will be electing COBRA. It provides information about a QB’s rights and obligations regarding a specific qualifying event and available COBRA coverage. It must be provided to QBs within 14 days after the plan administrator is notified of the qualifying event. However, if the employer is the plan administrator, the notice must be provided within 44 days of the qualifying event or the loss of coverage (whichever is later). The COBRA notice regulations include a model election notice as well.
- Notice of Unavailability. This is a notice mandated by the COBRA notice rules. If an individual gives notice of a qualifying event, but for some reason is not entitled to COBRA coverage, the plan administrator must give the individual an explanation of why coverage is not available. The deadline for this notice is the same as for the election notice. There is no model notice.
- Notice of Early Termination. Normally, COBRA coverage will terminate at the end of the maximum coverage period. If coverage terminates early, QBs must be notified. This notice must be provided “as soon as practicable” after it is known that coverage will terminate (or has terminated). It must contain the reason for the early termination, the date coverage terminated or will terminate and a description of any available conversion rights. There is no model notice.

COMPLIANCE SURVIVAL

COMPLIANCE COMMUNICATIONS

Unfortunately, providing an incomplete notice is as if it was not provided at all.

The general notice must contain the following information to be compliant:

- The plan name;
- The name, address and phone number of a contact person who can provide information about the plan and COBRA;
- A description of COBRA coverage under the plan (including who can be a QB, the types of qualifying events under the plan, a description of the maximum coverage period and ways to extend it, and the plan's requirements for payment);
- The plan's procedures for QBs to provide notice of certain qualifying events or Social Security Administration (SSA) disability determinations;
- A statement that the notice does not fully describe COBRA coverage or other rights under the plan and that more information is available from the plan administrator or the SPD; and
- A statement regarding the importance of advising the plan administrator of any change of address.

The election notice is the most detailed notice, since it relates to a specific qualifying event for specific QBs. It must contain the following elements:

- The plan name;
- The name, address and phone number of a contact person who can provide information about the plan and COBRA;
- Identification of the specific qualifying event;
- The date plan coverage will terminate;
- Identification of the QBs by status or name;
- A statement that each QB has an independent right to elect COBRA coverage;
- A description of the COBRA coverage under the plan;
- The amount that each QB is required to pay for coverage and payment procedures
- An explanation of how to elect and the date by which the election must be made;
- The consequences of failing to elect or of waiving COBRA coverage;
- The duration of COBRA coverage and how coverage may be extended;
- An explanation of the QB's responsibility to provide notice of a second qualifying event or SSA disability determination or no longer disabled
- A statement that the notice does not fully describe COBRA coverage or other rights under the plan and that more information is available from the plan administrator or the SPD; and
- A statement regarding the importance of advising the plan administrator of any change of address.

COMPLIANCE SURVIVAL

COMPLIANCE COMMUNICATIONS

ADDRESSING THE NOTICE

If the employee and dependents living at the same address are effective or lose coverage due to a COBRA event at the same time and, only one notice is required to be provided – it should be addressed to the employee and covered spouse.

A dependent spouse added or any dependent dropped for a COBRA event at a different time from the employee should be provided their own General and/or election Notice.

ANY covered dependent whose permanent home address is different from that of the employee's must be provided their own separate COBRA notices.

PROVIDING THE NOTICE

Both the COBRA and HIPAA laws specify that the minimum communication method should be 1st Class Mail – a “manner in which, if the notice is not deliverable, it will be returned to the sender. “ But remember, compliance liability is not only providing the notice but, proving it was provided. How can you prove you have sent something 1st class mail?

While many rely on the costly Certified Mail process, recent court cases have shown this method to fail the compliance requirements – too many loop holes in Certified Mail – it has lost in COBRA court **SIX** times!.

Another mailing system, Certificate of Mail, while challenged in court numerous times, has never failed!

CERTIFICATE OF MAIL – POSTAL SERVICE FORMS

- **PS Form 3817 for three or fewer letters**
- **PS Form 3877 – the Certificate of Mail Log - more than three letters**

The Certificate of Mail or Proof of Mail method provides a more cost effective, fail safe mailing method that has never lost in COBRA court.

The 2004 regulations provide that compliance notices can be provided in the SPD, assuming the SPD is by ERISA requirements.

COMPLIANCE SURVIVAL

COMPLIANCE COMMUNICATIONS

ELECTRONIC NOTICES

The law allows electronic communications of the COBRA notice – by the DOL’s electronic distribution regulations – DOL Regulation- 2590.606-1(f) –but, after reviewing the requirements, most administrators simply mail the notice.

- A. The Administrator takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents
 - a. (1) results in actual receipt (e.g. using electronic features such as return-receipt or notice of undeliverable items, conducting a periodic review to confirm receipt) and
 - b. (2) protects the confidentiality of personal information relating to the individual accounts and benefits.

- B. The electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format and content requirements applicable to the particular document (e.g. all information and documents required for making application for coverage . . .)

- C. Notice is provided to the individual, in the electronic or non-electronic format, at the time the document is furnished electronically, that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted and of the right to request a paper version of the document (e.g. “this is important and time sensitive information regarding insurance benefits – if you would rather receive a paper copy of this information please notify _____ immediately.”)

- D. Upon request, the individual is furnished with a paper version of the document

The regulation further provides that the above rules only apply to two categories of individuals.

- 1 – plan participants who have the ability to effectively access documents furnished in electronic format at any location where the participant is reasonably expected to perform his or her employment duties;
- 2 – with respect to whom access to the employer’s or sponsor’s electronic information system is an integral part of his or her employment duties.

COMPLIANCE SURVIVAL

COMPLIANCE COMMUNICATIONS

ELECTRONIC NOTICES (*continued*)

It is required that the administrator obtain

- 1 – Consent of the participant to receive the documents electronically and,
- 2 - In the case of documents to be furnished through the Internet or other electronic communication networks, have consented or confirmed consent electronically, in a manner that reasonably demonstrates the individual's ability to access information in such electronic form and have provided an electronic address for receipt of the documents.
- 3 – The Plan is required to notify these individuals (in either electronic or non-electronic form) BEFORE obtaining their consent, of
 - a) the types of documents to which the consent will apply,
 - b) the fact that the consent can be withdrawn at any time without charge,
 - c) the procedures for withdrawing consent and for updating their electronic address;
 - d) the right to request a paper version of the electronically furnished document;
 - e) any software or hardware requirements for accessing and retaining the documents

REALITY CHECK – before sending an electronic notice you must tell them what notices you will be providing electronically and receive consent they are willing to receive the information in that manner – again, not only from your employee but, from the qualified beneficiary.

Once provided, you must have a system that will confirm receipt – can you really do that – all you confirm is that the e-mail was received by *someone* and *someone* opened it up. Biggest problem we have seen is sending to personal e-mail addresses – say an employee leaves the company and gives consent for the notice to be sent electronically to the personal e-mail address – that address may be a “family” address. Who logged on to the e-mail first – them or their kids? Who actually received the letter? Did the kids delete it?

Electronic notices in the “real world” really give more liability than you can imagine.

COMPLIANCE SURVIVAL

IMPORTANT COBRA CASE LAW REFERENCE GUIDE

While many concern themselves with the IRS imposed penalties of the COBRA and HIPAA laws, a greater concern should be directed to the possibility and reality of litigation. To gain a full understanding of the provisions of the laws, one must be knowledgeable of not only the law and its guidelines, but also of the lawsuits.

The old adage of “learning from your mistakes” is a true one. But, reviewing lawsuits provides true compliance understanding and betters the adage – we learn from other people’s mistakes.

Over the years, several hundred lawsuits have made their way into the federal court system. An untold number of cases are settled out of court each year. Once the regulations began to be finalized in 1999, 2001, 2004, the number of court cases and the dollars awards began to increase.

As with any litigation, there is never a financial win. Even if the court rules in the favor of the employer, the financial burden of that win is costly. An ever-constant vigil of proactive awareness of all aspects of the law is the best defense to compliance.

The following pages may begin your “Important COBRA Case Law Reference Guide” – not the largest settlements, not the most blatant compliance failures but, each has strengthened the law in critical areas.

The primary compliance action is providing a notice. Such a simple process but, you will notice that a number of examples here involve failure to provide a COBRA notice or being able to prove it was properly provided.

Lawsuits provide clear understanding of gray areas of the law, clarify administrative responsibilities and can actually increase compliance responsibilities.

Don’t skip over reading these COBRA cases – you may find that you have some of the same failures but, haven’t been caught yet. Let from other people’s mistakes.

“We don’t live by the law – we live by the lawsuits!”

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

Degrise v. Sprint Corporation, 2002 U.S. App. (5th Cir. 2002)

PROVIDING THE NOTICE

This case is a recent reversal of certified mail cases. In this instance Sprint sent the COBRA election notice by certified mail. It was returned undeliverable. The 5th Circuit Court of Appeals ruled that Sprint do not know the reason the letter was not delivered and they had performed their “good faith effort” to provide the notice.

The plan administrator in this case sent a COBRA election notice by certified mail, return receipt requested, to an employee who had been terminated a week earlier. The post office twice attempted to deliver the notice to the employee, who was out of town on a three-week honeymoon. The post office left the employee a notice that there was a certified letter for him at the post office. The post office’s notice apparently did not indicate who had sent the certified mail. When the employee sought on two occasions to retrieve the letter, postal workers could not find it and advised him to check again. The post office later located the letter but sent it back to the plan administrator marked "undelivered." This occurred less than three weeks after the COBRA notice was originally sent, which means that the plan administrator knew for several weeks before the 60-day COBRA election period expired that the employee had not received his COBRA election notice.

The issue in the qualified beneficiary’s lawsuit for COBRA coverage was whether "a company meets its notification duty under COBRA by sending a letter by ‘certified mail’ to an individual's last known address even when the company knows that the individual did not actually receive the letter." The Fifth Circuit Court of Appeals held that COBRA requires no more than a "good faith" attempt to provide the required election notice. The court found that mailing the notice by certified mail—a type of first-class mail—satisfied the plan administrator’s obligation to make such a good faith effort. The return of the letter as "undelivered" did not change the outcome because the plan administrator did not know why the letter was not delivered and was not responsible for the letter’s going undelivered.

"Therefore, the plan administrator did nothing to undermine the presumption of ‘good faith’ established under the case law once it attempted to notify [the employee] of his COBRA benefits by certified mail."

Amazingly, this same Court reached an opposite decision against American Airlines— the facts were almost a mirror case – except the qualified beneficiary made American Airlines aware they had not received their COBRA notice within the 60 day election period.

You wonder if the Postal Service being unable to locate the letter – TWICE – has any bearing on the results of this case.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

SUPREME COURT RULING – JUNE 1998

COBRA and OTHER COVERAGE

This case is gave clarification to COBRA and Other Coverage eligibility situations including enhancing COBRA eligibility for Medicare entitled participants.

In *Geissal v. Moore Medical Corporation*, the Supreme Court ruled that employers must provide COBRA continuation coverage to individuals who have other group health plan coverage before the date of their COBRA election.

While employed, Geissal was covered under Moore's group health plan as well as under the health plan provided by his wife's employer. After Geissal's employment was terminated, he was offered and elected COBRA. After six months of premium payments, the employer informed him that there had been a mistake. According to the employer, since Geissal had been covered by another group health plan on the date of his COBRA election, he was not entitled to COBRA coverage.

Geissal brought suit charging that Moore Medical violated COBRA. The lower court sided with the employer, ruling that since group health plan coverage was in effect at the time of the COBRA election, Geissal was ineligible for COBRA coverage. The Court of Appeals for the Eighth Circuit agreed.

The Supreme Court heard the case to resolve a conflict among the federal circuits on whether ERISA §602(2)(D)(i) allows employers to deny COBRA continuation coverage to qualified beneficiaries who are covered under another group health plan at the time of the COBRA election.

Under ERISA §602(2)(D), COBRA coverage may cease on:

...[t]he date on which the qualified beneficiary first becomes, after the date of the election (i) covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, or (ii) entitled to benefits under title XVIII of the Social Security Act.

Moore claimed that Geissal's coverage under his wife's employer group health plan defeated the claim for COBRA coverage after his election to receive it. The employer argued that the deciding factor is whether, at any time after the election, the beneficiary is covered by another group health plan. They also argued that Geissal was not covered under his wife's employer plan until after his COBRA election - that was when that coverage became primary.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

SUPREME COURT RULING – JUNE 1998 (cont.)

The Supreme Court ruled that the employer's interpretation did not square with the plain meaning of the statute. The statute does not excuse the employer if the beneficiary "is" covered or "remains" covered on or after the date of the election. In addition, the statute does not suggest that it matters which plan is primary.

Instead, §602(2)(D)(i) speaks in terms of "becom[ing] covered," and this event is significant only if it "first" occurs "after the date of the election." Since Geissal was covered under his wife's employer group health plan continuously — before, during and after the date of his COBRA election — the employer could not cut off his COBRA coverage.

The court rejected the employer's argument that the first moment of coverage on the day following the COBRA election is the moment the beneficiary "first becomes" covered after the date of the election. The court also rejected the "significant gap" argument adopted by some other courts. This argument makes a case for COBRA eligibility in the case of a "significant gap" between the coverage offered by the employer's plan and that offered by the beneficiary's other group health plan. The court ruled that there was no statutory support for this position. Instead, the statute provides that coverage under a later-acquired group health plan will not terminate COBRA rights if that plan limits or excludes coverage for a preexisting condition of the beneficiary.

The Supreme Court acknowledged that its ruling will allow individuals who obtain coverage under a group health plan (as an employee or otherwise) between the date of the qualifying event and the COBRA election to elect continued coverage. So if a COBRA beneficiary obtains a new job with health coverage (with no exclusion or limitation for his condition) in the interim between the qualifying event and the election, he is eligible for COBRA. If the new job and coverage come after the election date, he is not.

A further consequence of the court's interpretation of the statute is that a plan may not deny COBRA coverage merely because the beneficiary becomes entitled to Medicare benefits before the date of his election for COBRA coverage.

The Supreme Court's decision in Geissal is contrary to proposed Treasury regulation 1.162-26, Q&A #38. However, the IRS noted the Treasury Department's intention to reverse its position effective June 8, 1998 (the date of the court's decision). The IRS also said that it will not assess excise taxes under Code §4980B for any period before June 8, 1998, during which a plan sponsor relied on the proposed regulation.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

BOWERMAN v. Wal-Mart Stores, Inc. -- 7th Cir. 2000

REHIRED – MISINFORMATION - COMPLIANCE OBLIGATIONS just AS A NEW HIRE

This case gave clarification to the employer responsibility of explaining insurance benefits to a rehired employee. However, please remember, this situation began in 1995, before HIPAA pre-existing condition credit and no pre-existing condition wait for maternity was allowed. The reason we include this case in the guide is because it is an excellent example of the problems that can result from an employer’s attempt to “give advise” instead of giving facts and allowing the participant to make their own decision.

Ms. Bowerman was covered under the Wal-Mart Stores Inc. insurance group health plan. She quit her job and her coverage ended on her last day of work. During her exit interview, she was given her COBRA election materials. A few days later, she visited her doctor and discovered she was pregnant. She elected COBRA coverage and her 45-day payment deadline was October 9, 1995. She went to work for another company but, she didn’t like the job, so she quit and returned to work at Wal-Mart exactly one month after she had originally left Wal-Mart employment. Shortly after she returned to Wal-Mart, she met with the person in charge of plan enrollment for her department. While discussing re-enrollment in the plan, she asked the enrollment representative if she needed her COBRA coverage. Her told her that she didn’t. The Wal-Mart election packet also included a discontinuance form. Instead of paying her COBRA premium, she returned the form and noted her reason for discontinuance as “I went back to work . . . so my insurance is still in effect.”

The Wal-Mart program included a rehire provision allowing employees terminated and then rehired within 12 months to have the normal 90-day waiting period waived. However, rehires are still subject to the plan’s 12-month pre-existing condition waiting period. Again, had this situation occurred after HIPAA legislation, the pregnancy could not have been treated as a pre-existing condition.

The employee immediately began to incur pregnancy-related medical expenses and receiving notice of denied claims. Over the course of the next few weeks, both the employee and her doctor contacted the plan numerous times but, never received a satisfactory reason for the denials. Even the explanation of benefits failed to provide conditional rational for the denial. In a recorded phone call, the company’s representative emphasized that all of the expenses occurred after the employee’s rehire date and Ms. Bowerman was told, “I will get this fixed for you, OK?”

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

BOWERMAN v. Wal-Mart Stores, Inc. -- 7th Cir. 2000 (cont)

Very significant to the case was the fact that this phone call occurred well before the October 9 COBRA premium deadline. However, it was not until 5 months later that the employee was first told that her claims were being denied because of a pre-existing condition. Had she been advised of this upon her original inquiry, she could have avoided the conflict by paying for COBRA coverage during her one-month gap – then she would have had continuous coverage.

Not only had Ms. Bowerman been advised incorrectly (even though the information was received informally), the court found that the company's SPD and COBRA materials were also ambiguous due to their failure to explain that electing COBRA coverage would "bridge the gap" in coverage for a rehired employee and possibly prevent application of a pre-existing condition waiting period.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

MARSH v. Omaha Printing Co. – 8th Circuit 2000

SOCIAL SECURITY DISABILITY EXTENTION CREITERIA

This case involves a delayed Social Security Disability Certification that resulted in a COBRA participant losing eligibility for the 11-month extension of COBRA coverage. This emphasizes the importance of receiving Social Security Disability Certification within the original 18 months of COBRA coverage.

COBRA law provides the opportunity for Social Security Disability Certified participants to extend the 18-month COBRA coverage to 29-months. The law specifies specific eligibility provisions for the extension – the date of disability must be before or at a maximum, within 60 days of the beginning of the original 18-month COBRA period; the Qualified Beneficiary must provide the Administrator a copy of the Social Security Disability Certification form within 60 days of the determination; Social Security Disability Certification must be received within the original 18-month COBRA period.

Mr. Marsh terminated employment and elected COBRA coverage in July 1995 when he suffered a heart attack that left him permanently disabled. He applied for Social Security Disability benefits in August 1995 but, never received certification. At the end of his 18-months period, he applied for the 11-month extension but, since he had never received Social Security Disability approval, his request for the extension was denied. He then suffered another heart attack and incurred approximately \$80,000 in medical expenses.

In August 1998, more than 3 years from his original application, Social Security determined that Mr. Marsh had been disabled since July 1995. Mr. Marsh again attempted to obtain the 11-month extension of his COBRA coverage. But, the court dismissed his claim. On appeal, the employee argued that his doctor's determination of disability made within the original 18 month of CORBA should have been sufficient to allow the extension.

The Eighth Circuit denied the appeal quoting that the COBRA statute plainly required a disability determination from the Social Security Administration within the original 18-month period.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

PHILLIPS v. Saratoga Harness Racing, Inc. – New York 2000

FOREIGN DIVORCE NOT RECOGNIZED AS A COBRA EVENT

This case determined that a foreign divorce decree that had been determined null and void by a U. S. Court was not a COBRA qualifying event and did not require the employer to offer COBRA continuation. Even though the employer won in court, this case creates the question of documentation required to determine a proper COBRA qualifying event.

An employee divorced his spouse in the Dominican Republic without his spouse's knowledge. He presented the Dominican divorce decree to the administrator and advised them that he wanted to drop his ex-spouse and add his new spouse. The administrator dropped the spouse as requested and provided the covered employee with a COBRA election notice that the employee was supposed to give to his purported ex-spouse. Seventeen months after the Dominican court entered the divorce decree, a New York State court declared the decree null and void because the spouse had not been given adequate notice of the divorce nor the opportunity to be heard. During the past months, she had incurred significant medical expenses. The spouse claimed she had never received a COBRA election notice. The court dismissed her case for lack of matter jurisdiction. The court explained that for the purposes of COBRA, the "finalization" of the divorce must occur. And, since the court had declared the Dominican divorce null and void, there had been no COBRA qualifying event.

The employer is actually lucky that the Dominican divorce was declared null and void and not a COBRA qualifying event. If it had a recognized divorce, the employer would have likely lost the case for COBRA coverage because proper COBRA notification had not been given. But still, this case brings a question of required documentation. Should, in divorce and legal separation situations, an employer give notice of COBRA eligibility but, explain that if the divorce decree is later invalidated, COBRA coverage may be negated? Maybe instances of this type is what gave us the "dropped in anticipation of a qualifying event" provision.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

McKNIGHT v School District of Philadelphia – U. S. District Court 2000

GROSS MISCONDUCT

While the COBRA law has never (and likely never will) defined gross misconduct, this case looks to another source to determine a definition – the applicable state’s unemployment insurance law that includes “willful misconduct” wording.

A teacher was charged with criminal sexual assault against a former student. The charges were later dismissed. The plaintiff was fired and the school district did not offer COBRA continuation because of the gross misconduct dismissal. Mr. McKnight brought suit against the school district for a number of issues related to his firing including the school’s failure to offer COBRA continuation. The school made motion to dismiss the non-offering of COBRA stating the plaintiff had been fired for gross misconduct and was not entitled to COBRA continuation.

The court denied the school district’s motion to dismiss. The court held that whether an arrest and subsequent dismissal of criminal charges constituted gross misconduct was an issue of fact to be determined at trial. The plaintiff provided evidence that he was fired not because of gross misconduct but because he had been arrested. He emphasized the point that he had been awarded unemployment insurance benefits because the school district failed to establish willful misconduct by the plaintiff.

NOTE: Once again we emphasize, when involved in a gross misconduct firing, the least of your concerns should be whether to offer COBRA continuation or not – be sure your firing sticks.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

Stormont-Vail Health Care, Inc. v. U.S. Dept. of Labor EBSA, 2010 WL 2132004 (D. Kan. 2010)

GROSS MISCONDUCT FIRING

While this suit involved denial of the ARRA subsidy and a Department of Labor appeal for that subsidy, the details of the case once again put the spot light on a gross misconduct firing problem.

The employee in this case was terminated for "mooning" a male nurse and subsequently denied COBRA coverage based on the employer's decision that her termination was for gross misconduct.

She then filed with the DOL for expedited review of the denial under the premium subsidy provisions of the American Recovery and Reinvestment Act of 2009 (ARRA). After obtaining information from both the employee and the employer, the DOL issued a determination letter stating that the information did not support a finding of gross misconduct and that the employee was entitled to a premium subsidy.

The employer asked the court to ignore enforcement of the DOL's determination, arguing that the employee was terminated for gross misconduct and was not entitled to COBRA at all, much less a premium subsidy.

Showing deference to the DOL, the court denied the employer's request. The court ruled that the employer was unlikely to succeed on the merits of its claim that the employee was terminated for gross misconduct, noting that although the "mooning" incident was intentional, willful and reckless, it was also a single, isolated, impulsive incident "which only harmed workplace protocol." The court also rejected the employer's argument that the use of the expedited review procedure to determine the basic issue of gross misconduct was not authorized by ARRA. The court ruled that it made "little sense" to expedite the decision on whether the subsidy was available, but then wait for a more extended process to determine whether she was eligible for COBRA at all. It also held that, given the balance of interests, the employer had been given enough opportunity to participate in the review process to satisfy due process standards and rejected the employer's challenge on this basis as well.

COMPLIANCE SURVIVAL

COBRA COURT CASE REFERENCE GUIDE

Brown v Neely Truck Line, Inc. – U. S. District Court for the Middle District of Alabama 2001 PROVIDING THE NOTICE

This case involves the inability of the employer to prove a COBRA notice had been provided and resulted in Neely Truck Line paying \$25,000 in claims and over \$5000 in penalties (\$10 per day for each day the notice was not provided – with interest).

Earl Brown and his wife Linda were covered through the Neely Truck Line. Insurance was critical to the family because of Mrs. Brown's diabetes. However, on September 6, 1991, Mr. Brown terminated Neely truck Lines employment in order to begin work at All State Packaging. After a 90-day employment waiting period, the couple was covered for insurance benefits through the All State Packaging plan. The new plan included a pre-existing condition waiting period. During this pre-existing condition waiting period, Mrs. Brown incurred approximately \$25,000 in medical expenses. The Browns contend that Neely Truck Lines never made a COBRA offering to them. Though Neely Truck Line contends they sent a COBRA election form to Mr. Brown, they were unable to provide proof and convince the court such notice had been provided. For this reason, they lost the court case and paid over \$34,000 in claims and penalties. Certificate of Mail would have been a good investment.

Of course, had this situation occurred after 1997, the HIPAA portability provisions would have allowed Mrs. Brown the opportunity of pre-existing condition credit and she would have likely never been out the medical expense. However, Neely Truck Lines would have still lost the COBRA case.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

Claudio-Gotay v. Becton Dickinson Carbide – First Circuit Court of Appeals -- July 2004

PROVIDING THE NOTICE

This case involved the employer’s lack of proof of providing a COBRA election notice upon termination of employment. Even though the employer produced copies of the notice from their files, they failed to produce any evidence that the notice has actually been provided to the employee.

In this case, the First Circuit Court of Appeals reviewed a case where summary judgment has been granted in favor of an employer on a claim for failure to notify an employee of his COBRA rights. Claudio-Gotay was terminated and claimed that his employer violated COBRA by failing to inform him of his rights to continuation benefits. His employer produced a COBRA notification letter dated 5 days after the termination, but could not produce any evidence that he actually received the notice. The employee denied receiving the notice. The Court found that summary judgment was inappropriate because there was a material issue of fact as to whether the COBRA notice was actually sent.

This decision seems to conflict with the COBRA regulations that do not require an actual acknowledgement from an employee that a COBRA notice was received. However, the decision merely reversed the lower court for lack of evidence. The Appeals Court determined that the trial court record did not contain clear and convincing evidence that the employer had a notification policy, that the policy was followed and that reasonable steps were taken to ensure former employees received COBRA notices.

This decision, coupled with the 2004 COBRA regulation amendments, makes it even more essential that all employers have a specific written COBRA policy that explains how notices and forms are issued, when they are issued and what steps the employer takes to comply with the obligations of COBRA.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

Lopez v. Premium Auto Acceptance Corporation – Fifth Circuit Court of Appeals – 2004

HOW LATE IS TOO LATE?

Gloria Gutierrez was an employee of Premium Auto Acceptance Corporation and a participant in the company's health care plan. On Aug. 28, 1997, three days after returning from surgery to treat her lung cancer, Premium terminated Ms. Gutierrez. Because Premium claimed that it had fewer than 20 employees and thus was not subject to COBRA, the company did not provide Ms. Gutierrez with a notice informing her about continuation of her health insurance coverage under the company's plan. Ms. Gutierrez's insurance was canceled after 30 days following her termination. Ms. Gutierrez died on Oct, 25, 1998, leaving her daughter, June Lopez, as the sole heir. Ms. Lopez filed suit that Premium Auto Acceptance Corporation failed to provide proper notice of Ms. Gutierrez' continuation of coverage rights.

The Fifth Circuit Court of Appeals has held that a lawsuit filed more than four years after an employer allegedly failed to notify a terminated employee of her right to elect COBRA coverage was time-barred (i.e., was filed too late).

While the COBRA law contains no "Statute of Limitations" the trial court applied the Texas two-year statute of limitations under the unfair insurance practices provision of the Texas Insurance Code. Because such state-law claims are subject to a two-year statute of limitations and the suit had been filed more than two years after the employee's termination, the trial court entered judgment in favor of the employer on the COBRA claim.

The Fifth Circuit upheld the judgment on appeal, agreeing that a state-law claim for unfair insurance practices was most analogous to the COBRA claim. This is a most unusual circumstance – applying a state *insurance* statute of limitations to the Federal COBRA *employer liability* law.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

Gomez v. St. Vincent Health, Inc., 2010 WL 1854106 (S.D. Ind. 2010)

COURT AWARDS NO PENALTIES FOR LATE BUT CORRECTED ELECTION NOTICES BUT AWARDS BENEFITS OF \$396

During an employer self-audit, it was discovered that COBRA notices had not been provided to 3 ½ years earlier – the employer made it right and offered COBRA continuation. All was forgiven but, they had to defend a law suit that resulted in a claim payment of less than \$400.

After the two employees in this case were terminated, they were never provided timely notice of their COBRA election rights. Three and a half years later, when an audit revealed the notice failures, election notices were sent to each employee, offering them the opportunity to retro-actively elect COBRA and to work out a payment schedule. Neither employee took up the offer. Thereafter, an attorney who had unsuccessfully sued the plan in an earlier COBRA case solicited the employees, and they sued to recover statutory penalties at the maximum rate of \$110 per day for the late notices. One employee also sued to recover her out-of-pocket payments of "something in excess of \$700" (she hadn't retained any receipts) for prescription drugs in the first month following her loss of plan coverage.

After considering whether the employees had been prejudiced and whether there was any "bad faith, gross misconduct or ill intent" by the plan administrator, the court found no basis for awarding penalties. In particular, the court relied on testimony from one employee that, after she lost her job, she could not afford COBRA coverage and had received medical care through an indigent program, and on testimony from the other employee that she obtained coverage through a new employer after only one month. In addition, it appeared that the notice failures were due to good faith efforts by the employer (a large hospital chain) to centralize benefits administration. However, following precedents from other courts, the court did award one employee her out-of-pocket expenses of \$700, less the \$304 COBRA monthly premium, for an award of \$396.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

Emilien v Stull Technologies Corporation – Third Circuit – 2003

Failure to define key terms in COBRA notice could prove costly – notices must explain benefits in layman's terms

Marie Emilien was employed by Stull Technologies Corporation (STC) at its Randolph, New Jersey, plant. On August 18, 1998, the company announced that it was closing the Randolph plant and transferring its operations to another plant located in Somerset, New Jersey. The employees were given two options: (1) transfer to the new Somerset plant or (2) continue working at the Randolph plant through November 6, 1998. The individuals who decided to remain at the Randolph plant were eligible for a special severance program (SSP). The terms of the SSP required employees to sign a general waiver and release and render satisfactory service at the Randolph location "on a continuous basis from now until November 6, 1998 or until released on some earlier date by [STC]." On October 11, 1998, Emilien elected to stay at the Randolph plant and participate in the SSP. Ten days later, Emilien became ill while at work and was transported by ambulance to the Morristown Memorial Hospital. She returned to her home for a short period of time but remained unable to work. She was hospitalized once again on December 28, 1998, and remained there until her death due to complications from HIV and tuberculosis on January 7, 1999. During Emilien's hospital stay, STC allegedly sent a letter to her home stating that it had decided to retroactively "separate" her employment effective October 21. The letter also contained a notice that she would be excluded from the company's group medical benefit plan based on her termination and thus must complete and submit a COBRA election form to maintain coverage. When she didn't return the form, the company terminated her medical coverage in November 1998. Following her death, Emilien's husband filed a lawsuit against STC, claiming the COBRA notice was inadequate. Under COBRA, an employee must be provided at least 60 days to decide whether to convert from group to private medical insurance. That time period runs either from the occurrence of a "qualifying event" (*i.e.*, termination) or when notice of the qualifying event is provided to the beneficiary (whichever is later). If the notice is deficient, the employer may be held liable for a former employee's medical costs.

Upon appeal, The Third Circuit held that the employer's COBRA notice wasn't sufficiently clear to discharge the company from liability for Emilien's medical expenses. According to the court,

"This is because it is highly unlikely that a lay person would understand the meaning of the term 'Qualifying Event' without any explanation of that term." "Because [STC] failed to provide [Emilien] with a readily comprehensible COBRA conversion form," the Third Circuit concluded, "it is liable for her health care costs."

This situation demonstrates the importance of sending timely, updated and complete COBRA notices.

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COBRA CASE LAW REFERENCE GUIDE

[Ratcliff v. Psychiatric Solutions, Inc., 2010 WL 2814418 (W.D. La 2010)]

COURT RULES COBRA ELECTION NOTICE AND SUBSEQUENT LETTERS WERE NOT MISLEADING

The employee in this case sued her employer, claiming it erroneously terminated her COBRA coverage. The employer (as plan administrator of its health plan) claimed that it correctly terminated her coverage because she failed to pay her COBRA premiums on time. The employee argued that she believed her payments were timely based on the notices and letters she received. The election notice, which she characterized as misleading, informed her of her eligibility to participate in the plan and her obligation to pay monthly premiums in a specific amount if she chose to enroll in the plan. Among other things, the notice also stated that all initial premium payments had to be paid within 45 days of the day the enrollment form was signed and dated, and provided a detailed schedule for the first premium payment. Furthermore, after the employee enrolled and paid the initial premium, she was sent a letter confirming her enrollment and informing her that she had to make additional payments by a specific date. An additional courtesy letter was also sent, informing her that an additional payment had to be postmarked by a specific date to prevent termination of the employee's COBRA coverage.

The court ruled for the employer, finding that the election notice set forth the employee's obligations in a precise, unambiguous manner and that the employee failed to make timely payment despite the express terms of the election notice and subsequent letters, which were neither misleading nor ambiguous. The court also found unpersuasive the employee's excuse that she failed to open her mail and to read later correspondence about her election, ruling that this could not under any circumstances be a basis for finding that the employer did not give adequate notice.

Once the payment schedule is properly provided in the election notice, no additional payment communication is required in the law. It might not pay to get creative with the notices – use the model notices provided by the DOL. Any further notification about premiums via billing statements, late-payment reminder letters, coupons, etc., is optional.

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COBRA CASE LAW REFERENCE GUIDE

Fink v Dakotacare – Eighth Circuit – March 2003

EVERYONE WAS AT FAULT

This court case is the perfect example of the liability of every step of the compliance circle – notification and premium collection. Without proper indemnification, the employer may still have the compliance liability for the vendor’s actions.

In this situation, the court found all three - the employer, the TPA, and the carrier - liable to some degree for damages because they did not properly apply a premium payment and denied COBRA coverage to a qualified beneficiary. On appeal, the court ordered a trial to determine the amount of medical expenses incurred by the dependent of a former employee, and how to apportion liability. The parties: The appeals court noted that "all three defendants are potentially liable" because they each owed a duty to properly administer COBRA under the federal law, ERISA. The qualified beneficiary in this case sued three entities: her former employer, Platte Community Memorial Hospital; the employer's third party administrator, Dakotacare Administrative Services (DAS); and the group health plan carrier, Dakotacare. Dakotacare contracted with Platte to provide group health care to its employees; DAS agreed to administer coverage for Platte's qualified beneficiaries and to receive and appropriately distribute payments from qualified beneficiaries to the applicable health plan.

Margaret Fink, a former employee of Platte Community Memorial Hospital, elected COBRA coverage for herself and her daughter, Sarah, a 24-year-old college student. Both were covered under COBRA by Platte's group health provider, Dakotacare, as of February 1, 1997. In November 1997, Platte decided to switch group health providers from Dakotacare to Lincoln Mutual Insurance, effective January 1, 1998. Although Platte sent Ms. Fink notice informing her of the impending switch, there was a dispute as to whether that letter also informed her that she was required to switch to Lincoln Mutual if she wished to continue COBRA coverage. Neither party retained a copy of the letter. On December 23, 1997, Ms. Fink informed Platte that she did not want coverage under Lincoln Mutual because she was going to obtain health coverage with a new employer. But a few days later, Ms. Fink's daughter, Sarah, became hospitalized for treatment on December 29.

Ms. Fink paid the COBRA premium for January 1998 with a check payable to Dakotacare COBRA Services, enclosing the appropriate payment voucher. She testified that she paid this premium to ensure there would be no gap in her family's health insurance coverage because she didn't know when she would be covered by her new employer's plan, or when Platte's switch to Lincoln Mutual would take effect.

COMPLIANCE SURVIVAL

COBRA CASE LAW REFERENCE GUIDE

Fink v Dakotacare – Eighth Circuit – March 2003 (cont.)

Early in January, Dakotacare confirmed benefits for Sarah's treatment and assured Ms. Fink was covered under her COBRA plan. But on January 20, the carrier told her that COBRA coverage was terminated retroactively to January 1, and refunded her premium payment after first cashing her check. Margaret was informed that she would be billed for all of Sarah's medical expenses between January 1 and February 4, when she was discharged from the hospital.

According to the appeals court, Ms. Fink and her daughter Sarah are "legally entitled to continuation coverage for January 1998." Payment was made on time, in the right amount, payable to the proper payee, and prior to formally canceling her continuation coverage. The court went on to say: "Sorting out which defendant is liable for the denial of Ms. Fink's continuation coverage in January 1998 may be difficult...[but] it was not Ms. Fink's obligation to learn whether her January 1998 continuation coverage premium should be paid to Dakotacare or Lincoln Mutual." She paid the January 1998 premium in accordance with the plan in effect when the payment was made. Dakotacare and DAS, who were under contract to provide COBRA coverage and administer Platte's plan, were responsible for tendering Ms. Fink's payment to the proper provider, according to the court.

So many problems here – It appears that Dakotacare was at fault for cashing Ms. Fink's check and assuring her that Sarah's care was covered, then denying coverage retroactively. But, DAS, the employer's COBRA administrator was responsible for seeing that payment was properly credited and coverage provided. And, since there was no indemnification clause in the contract, the employer retains liability for everyone's errors! The appeals court noted that each of these parties, including the employer, owed a legal duty to the Finks to properly maintain Sarah's COBRA coverage, and any one or all of them can be held liable for the damages incurred.

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COBRA CASE LAW REFERENCE GUIDE

Maya v. Inspro Corporation, U.S. Dist. N.D. Cal. 2004

PROVIDING THE NOTICE

In this case, the former employee claimed that she never received COBRA election notices for her group medical and dental coverage. The employer, also the plan administrator claimed that it had sent the notices twice to her home address. When they were received notice from Ms. Maya's attorney that notice had not been received, another copy of the notice was sent to the attorney. The employee sued her former employer for, among other things, statutory penalties for failure to provide the required COBRA election notices.

The court granted summary judgment (that is, a judgment without a trial) in favor of the employer. As always, the court noted that COBRA does not require that the employer prove the employee actually receive a COBRA election notice, only that the employer make a good faith effort to send the notice in a manner reasonably calculated to reach the former employee. The court pointed to prior decisions in which other courts had found that "sending notice by first-class mail is sufficient notice as a matter of law." Because this employer provided undisputed evidence that it prepared and mailed the COBRA election notices in the ordinary course of business to the employee's last-known address, it was entitled to summary judgment.

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COBRA CASE LAW REFERENCE GUIDE

Torres-Negron v. Ramallo Brothers Printing, Inc., (D. Puerto Rico, 2002)

PROVIDING THE NOTICE

In *Torres-Negron v. Ramallo Brothers Printing* case an employer was fined \$24,390 for failing to provide a COBRA notice to its former Director of Human Resources following her termination. *Ramallo Brothers Printing's* case relied on the fact that she knew of her rights to COBRA – she was the one responsible for providing COBRA information to the employees.

In assessing statutory penalties of \$45 per day per qualified beneficiary, the Court held that it was not relevant that the plaintiff knew of her COBRA rights in absence of the notice. The employer had an affirmative duty to provide plaintiff notice of her right to continuation coverage and that duty was not mitigated by her knowledge of the law. In addition to ERISA penalties, the Court ordered the employer to pay the plaintiff's costs and attorney's fees.

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COBRA CASE LAW REFERENCE GUIDE

Poole v. Monmouth College (Superior Court of New Jersey)

SOCIAL SECURITY DISABILITY CRITERIA

Gertrude Poole was granted a medical leave of absence from Monmouth College in New Jersey in 1987. By late 1989, it was determined that Poole was not going to return to work. On January 2, 1990, Poole's contract expired, and tenure was not granted. She was notified of, and elected, COBRA continuation coverage. Shortly after January 2, Poole applied for Social Security disability benefits. On March 5, 1990, she was determined to have been disabled retroactively to December 29, 1989 (four days before her original COBRA Qualifying Event date). In August 1990, Poole learned of the disability extension amendment that had been passed by Congress the previous December, and she requested the 11-month extension of COBRA coverage. The college refused her request. Poole filed suit. The college defended its denial of the request, asserting:

1. The college did not know of Poole's disability at the time of her termination of employment.
2. Poole did not notify the college of the Social Security disability determination within the 60 days, as required by the statute.
3. Because the college was not aware of the changes in the law when it denied the extensions, its actions were taken out of ignorance, not out of malice.

As for the first defense argument, the court indicated that it is not necessary for an employer to know of the disability at the time of the Qualifying Event. To the second defense, the court ruled that an employer cannot impose a 60 day notice requirement on a Qualified Beneficiary unless the employer has previously notified the beneficiary of the 60 day reporting period in the COBRA notice. The court summarily dismissed argument number three with the old adage that ignorance of the law is not a viable defense. More importantly, perhaps, the court also stated that ignorance of the law in a situation like this indicates a possible breach of fiduciary responsibility under ERISA.

NOTE: The 2004 Final Regulations specify that the information regarding the Social Security Certificate timeline is no longer required in the COBRA General Notice (formerly Initial COBRA Rights Notice) – it is only required in the election notice. Because of this, the notification to the employer of administrator was changed to 60 days of Certification or 60 days of the beginning for COBRA coverage.

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COBRA CASE LAW REFERENCE GUIDE

Pethers v. Metro Lift Propane, 2010 WL 3023887 (E.D. Mich. 2010)

LATE NOTICE – BUT NO HARM

Yes, the employer admitted the COBRA notice was late in being provided but, the court refused to award penalties because the plaintiff could not show harm had been done to the qualified beneficiaries.

The employee in this case sued his employer (as plan administrator of its health plan) for an untimely COBRA notice. The employee received his election notice 64 days after his termination. The notice was dated much earlier, however, suggesting that the employer had provided it within the required 44-day period. Furthermore, the employer paid the employee's insurance premiums for two additional months, through the end of the month when he received the notice.

The court refused to assess penalties for a late notice since the employee could not show harm or prejudice. It noted that the employee had been provided coverage for an additional two months, the employee admitted that neither he nor his family was denied medical care or insurance coverage, and that he was not harmed by the delay in getting the notice. The court rejected the employee's claim that there should be penalties just because "it was wrong" for the notice to be late, the court pointed out that in the absence of any prejudice or bad faith, courts generally decline to impose penalties for noncompliance with COBRA's notice requirements.

Even if this complaint had been addressed to the DOL, it is likely that there would have been no penalty assessed – once the employer was made aware of their failure to provide a notice, they took action within 30 days to correct their mistake. Forgiveness.

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COBRA CASE LAW REFERENCE GUIDE

Crotty v. Dakotacare Administrative Services Inc., U.S. Court of Appeals for the Eighth Circuit*, No. 05-3798, August 2006

PROVIDING THE NOTICE

The administrator relied on a simple “log of letters sent” - Yes the audit log included the ex-employees’ name but, the court ruled the administrator had not taken sufficient measures to prove that a COBRA notice was sent. Employers must have a way of verifying notices are sent to particular individuals.

Kelly Crotty lost her job, which was a “qualifying event” under COBRA, triggering the duty by the plan administrator to send her a notice of her rights to extend health insurance coverage. She claimed the only letter she received was a notice informing her that she was no longer eligible to extend her coverage. She tried to retroactively reinstate her coverage to pay for surgery, but was denied, and she sued.

At trial, the plan administrator provided evidence of the procedures used in sending out COBRA notices, and provided an audit report showing that her name was on a list of those scheduled to receive a letter generated by a computerized system, but could not prove that a notice letter was in fact sent specifically to her.

The Court held this was not sufficient proof. It noted that while in some jurisdictions it is sufficient to show that the administrator took measures to send a notice “by means reasonably calculated to reach the recipient,” that was not enough in this case. Employers and plan administrators must be able to prove a notice was sent to a particular person.

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COBRA CASE LAW REFERENCE GUIDE

Delcastillo v. Odyssey Resource Management, Inc., — F.Supp.2d —, 2007 WL 878492 D.Neb. (March 12, 2007)

PEOs and COBRA – WHO HAS THE LIABILITY?

This case has a long explanation because of its procedural history - the facts are somewhat complex on a first reading. It is hard to follow unless you read all of the court opinions - i.e., the first district court opinion, the Eighth Circuit opinion and the opinion on remand. But, it is well worth reading to see how courts view liabilities.

Delcastillo's Injury

In August 1996, John Delcastillo was severely injured in a fall while working at a rail car repair facility owned by Houston J-M Corporation. Delcastillo began receiving health insurance benefits under a group policy issued by United Healthcare Insurance Company. Let's call that scenario **Employer 1** and **Insurance Company 1**.

Purchase of Employer 1 By Employer 2

Integrated Rail Products, which we'll call **Employer 2**, purchased the assets of Employer 1 in October 1997. IRP thereafter replaced the United Healthcare policy with a Reliance Insurance Company policy (**Insurance Company 2**). IRP was the policyholder on the Insurance Company 1 contract, but not the Insurance Company 2 contract, which became an important point of contention.

The PEO Arrangements

The facts now become a bit more complicated than presented above. When Delcastillo was injured, Odyssey Management, Inc. (**Odyssey 1**) served as the PEO of the **Employer 1** employees. Sometime after acquiring the assets of Employer 1, IRP (**Employer 2**) entered into another staff servicing Agreement with Odyssey Resource Management, Inc. (**Odyssey 2**) to provide employment and human resource services.

Descastillo Absent On Enrollment Day

Descastillo was obviously not present during the Employer 2/Insurance Company 2 enrollment given his injuries. He was thus "overlooked" according to the opinion. The appellate opinion states:

"The Loomis Company served as a third-party administrator responsible for paying claims on behalf of Reliance. To enroll eligible participants in the new health care plan, an Odyssey account manager, Linda Reyna, went to the IRP work site, where active employees filled out application forms that Odyssey sent to Loomis. The disabled Delcastillo was not at the work site and therefore was not enrolled in the plan. Delcastillo v. Odyssey Resource Management, Inc., 431 F.3d 1124, 1126 (8th Cir. 2005)"

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COBRA CASE LAW REFERENCE GUIDE

Delcastillo v. Odyssey Resource Management, Inc., — F.Supp.2d —, 2007 WL 878492 D.Neb. (March 12, 2007) (continued)

“The court of appeals also found that the defenses to a claim of coverage were contrary to reality and could warrant imposition of a drastic remedy. The court further intimated that a decision to engage PEOs as co-employers in order to alter participants’ rights to ERISA benefits might well violate ERISA fiduciary duties. In light of those findings, and based on its review of the record, the court finds that the evidence establishes Odyssey’s liability for wrongful denial of benefits under 29 U.S.C. Â§ 1132(a)(1)(B).

In this case a group of related “professional employer organizations” (“PEO’s”) defended a claim for benefits on the grounds that the plan participant was not eligible for coverage under a policy it acquired as policyholder. Aside from providing an insight as to what can go wrong in a transition of corporate ownership (the plaintiff was “overlooked” in enrollment), the opinions in the case show a limited judicial patience with defenses built around the “co-employer artifice”. In fact, the opinion suggests that use of defenses based upon the notion could violate ERISA fiduciary duties in some instances.

District Court Opinion

Due to the switch in coverage to Insurance Company 2, Decastillo lost coverage, though it took some time for the facts to be exposed. Descastillo and his wife, as his dependent on the plan, eventually sued on several theories, contending that the Odyssey defendants failed to provide adequate notice of COBRA rights, breached fiduciary duties, and were subject to statutory penalties for failure to provide requested plan information and the COBRA notices. The Odyssey defendants disavowed any responsibility. They argued that they had no duty to provide either benefits or COBRA notice because Odyssey was not the plan’s sponsor at the time of a qualifying event that would have triggered such a duty, and that Descastillo was not eligible for coverage under the new policy.

The district court held for the Plaintiff on all issues, finding the Odyssey defendants *alter egos* of one another in the process. From the Eighth Circuit opinion:

“After other defendants were dismissed, the district court held a two-day bench trial and concluded that Odyssey Resource Management and 1st Odyssey Group are jointly and severally liable to the Delcastillos for breach of ERISA fiduciary duties and for failure to provide the notices of their right to continuation coverage mandated by COBRA. The court awarded a total of \$306,866.11 for COBRA statutory penalties and compensatory

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damages and \$109,317.50 in attorneys' fees and costs. Delcastillo v. Odyssey Resource Mgmt., Inc., 320 F.Supp.2d 889, 901 (D.Neb.2004)

COBRA CASE LAW REFERENCE GUIDE

Delcastillo v. Odyssey Resource Management, Inc., — F.Supp.2d —, 2007 WL 878492 D.Neb. (March 12, 2007) (continued)

The Odyssey defendants appealed.

The Eighth Circuit Opinion - Replacement Coverage Not COBRA Coverage

The Eighth Circuit reversed the district court's opinion that the defendants' failed to provide COBRA notice, holding instead that Delcastillo continued coverage under a "replacement provision" in the Insurance Company 2 policy. The Court stated:

"In these circumstances, it does not matter whether John Delcastillo was working regularly when the Reliance policy [Insurance Company 2] was issued, or whether he was even an IRP "employee" [Employer 2] at that time. It is enough that he was a covered plan participant under the health care plan being replaced."

PEO Co-Employer "Artifice"

The Eighth Circuit had some harsh words, however, for the Odyssey defendants' attempt to evade responsibility by claiming that Delcastillo was not an employee entitled to coverage. To appreciate this admonition, one must note that the Odyssey defendants argued that the Replacement of Coverage provision did not apply because Odyssey Resource Management, Inc. (**Odyssey 2**) was the employer on the Insurance Company 2 contract and Delcastillo was not eligible under that policy.

The Court rejected this defense, stating:

"This contention is so contrary to reality and to the policies underlying ERISA that it jeopardizes judicial acceptance of the co-employer artifice . . . IRP engaged Odyssey as a limited co-employer for the purpose of sponsoring the replacement plan. The fact that IRP was the United Healthcare policyholder and Odyssey became the Reliance policyholder does not alter the reality that IRP obtained replacement coverage for its employees . . . If the right to ERISA benefits could be altered by the essentially non-substantive provision in Odyssey's contract with IRP making Odyssey a co-employer the decision to engage PEOs as co-employers might well violate ERISA fiduciary duties."

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COBRA CASE LAW REFERENCE GUIDE

Delcastillo v. Odyssey Resource Management, Inc., — F.Supp.2d —, 2007 WL 878492 D.Neb. (March 12, 2007) (continued)

Alter Ego Determination

Regarding the *alter ego* finding by the district court, the Eighth Circuit observed:

“Apparently, this issue arose in the district court when defense counsel intimated that the Odyssey defendants would be judgment proof because Odyssey Resource Management is a dormant shell and 1st Odyssey Group was not involved in the events at issue. Because this issue may lose its relevance given our disposition of the appeal, we decline to consider it at this time. We note, however, that a PEO organization that uses multiple corporate entities to frustrate the recovery of valid ERISA claims might become subject to drastic ERISA remedies, such as an order permanently enjoining the culpable parties from acting as a service provider to any ERISA plan.”

The Court remanded the case for further consideration of whether the Delcastillos were entitled to recover damages equal to their unreimbursed covered medical expenses during the period from February 1, 1999, to June 30, 2000 and for reconsideration of related issues.

Misrepresentations and Contradictions

On remand, the district court addressed the defendants’ conduct in no uncertain terms:

“The court notes that this action has been unnecessarily prolonged and this court’s task on remand has been needlessly complicated by Odyssey’s misrepresentations, obfuscation of issues, presentation of contradictory arguments, continued pursuit of untenable and unmeritorious claims, and apparent failure to properly designate the record to the court of appeals.”

The district court took particular umbrage at the defendant’s conduct in the appeal of the initial decision in the case. The stated that:

“On appeal, defendants successfully confused, conflated, and clouded the issues by omitting facts that would have explained this court’s findings and enhanced the Eighth Circuit’s understanding of the case.”

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Award of Unreimbursed Medical Expenses . . .

The district court turned to the issue of unreimbursed medical expenses, but not without first taking the defendants to task once again, as follows:

“As recounted above, and contrary to defendants’ representations to the court of appeals, plaintiffs prosecuted this action as an ERISA action for both wrongful denial of benefits, seeking the legal remedy of damages and breach of fiduciary duty, seeking equitable relief. . . The issue of whether and to what extent the Delcastillos were covered for health benefits from and after the date on which Odyssey became its plan sponsor is and always has been the heart of this lawsuit. Penalties for failure to provide notice of COBRA rights was merely incidental to the coverage claim.”

On the merits, the court held that the evidence established Odyssey’s liability for wrongful denial of benefits under 29 U.S.C. Â§ 1132(a)(1)(B), stating:

“At the time Odyssey ostensibly offered continuation coverage to the Delcastillos, Odyssey continued to maintain that the Delcastillos were not eligible under the policy and continued to deny claims submitted under the policy. . . An election of COBRA coverage by plaintiffs would have been futile. Accordingly, the court finds that Odyssey is liable for medical expenses that would have been covered had the Delcastillos elected COBRA coverage, as well as medical claims improperly denied from February 1, 1999 to June 30, 2000. The evidence adduced at trial established those damages were \$27,026.11 and judgment in favor of plaintiffs, together with interest at the legal rate, will be entered in that amount.”

And Penalties . . .

Though the Eighth Circuit determined that statutory penalties could be assessed under 29 U.S.C. Â§ 1132(c)(1)(A) for failure to provide either initial or election COBRA notice or for breach of fiduciary duty, the district court had in place an unchallenged alternative award of statutory penalties under 29 U.S.C. Â§ 1132(c)(1)(B) for failure to provide requested notice was not challenged on appeal.

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The court awarded the maximum penalty.

“. . . despite repeated requests beginning in mid-February 1999, no summary plan description or other plan documents were forwarded to the plaintiffs until August 9, 1999. The record establishes conduct at least bordering on bad faith by the defendants and also shows considerable prejudice to the plaintiffs. Accordingly, the court finds that statutory penalties in the amount of \$110.00 per day should be assessed against Odyssey and in favor of plaintiffs. Judgment for penalties in the amount of \$19,360 will be entered in favor of John Delcastillo, and judgment for penalties in the amount of \$19,360 will be entered in favor of Lois Delcastillo . . .

And Attorneys' Fees

Under ERISA, a court is authorized, in its discretion, to award a reasonable attorney fee and costs to either party. 29 U.S.C. Â§ 1132(g)(1). The court ruled that a “substantial award” was appropriate, stating:

“Application of the Westerhaus factors in this case favors a substantial award of fees to the Delcastillos. First, the court finds that defendants’ conduct, both with respect the Delcastillos and in the prosecution of this action and appeal, was egregious, bordering on bad faith. Second, there has been no showing that defendants lack the ability to pay. Third, the deterrent effect of an award of fees deserves considerable weight. An award of attorneys’ fees will serve as an incentive to Odyssey and other employing the PEO artifice to pay closer attention to their COBRA notice handling procedures when an employee departs under [similar] circumstances.”

Fiduciary Responsibilities - The Eighth Circuit stated that the interposition of a “co-employer” does not change the “reality” that it is the common law employer that is held accountable for whatever plans or policies the PEO puts in place. While the case demonstrates that the PEO also be held financially accountable, the following comment appears directed at employers using PEO’s:

“If the right to ERISA benefits could be altered by the essentially non-substantive provision in Odyssey’s contract with IRP making Odyssey a co-employer, the decision to engage PEOs as co-employers might well violate ERISA fiduciary duties.

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Who Is The Employer? - Relying upon contractual agreements in determining the employer can be risky. Regardless of context, the parties should consider substance over form in evaluating governing law. For example, for tax purposes, the IRS as stated:

“[t]he Service recognizes the complexity involved in the determination of whether a Worksite Employee is the common law employee of the PEO or the client organization (CO) . . .” For background on its common law test and the potential implications of test for employee benefit plans, including possible plan disqualification. Rev. Proc. 2002-21:

PEO As “Plan Sponsor” - For purposes of the statutory penalties, the district court attached liability to the PEO in its capacity as plan sponsor” *ERISA provides that the plan administrator is the one specifically so designated by the terms of the instrument under which the Plan is operated or, if no administrator is ... so designated, the administrator is the plan sponsor. The plan does not identify an administrator. The evidence shows, however, that Odyssey was the plan sponsor and that Odyssey made claims and eligibility decisions.*

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